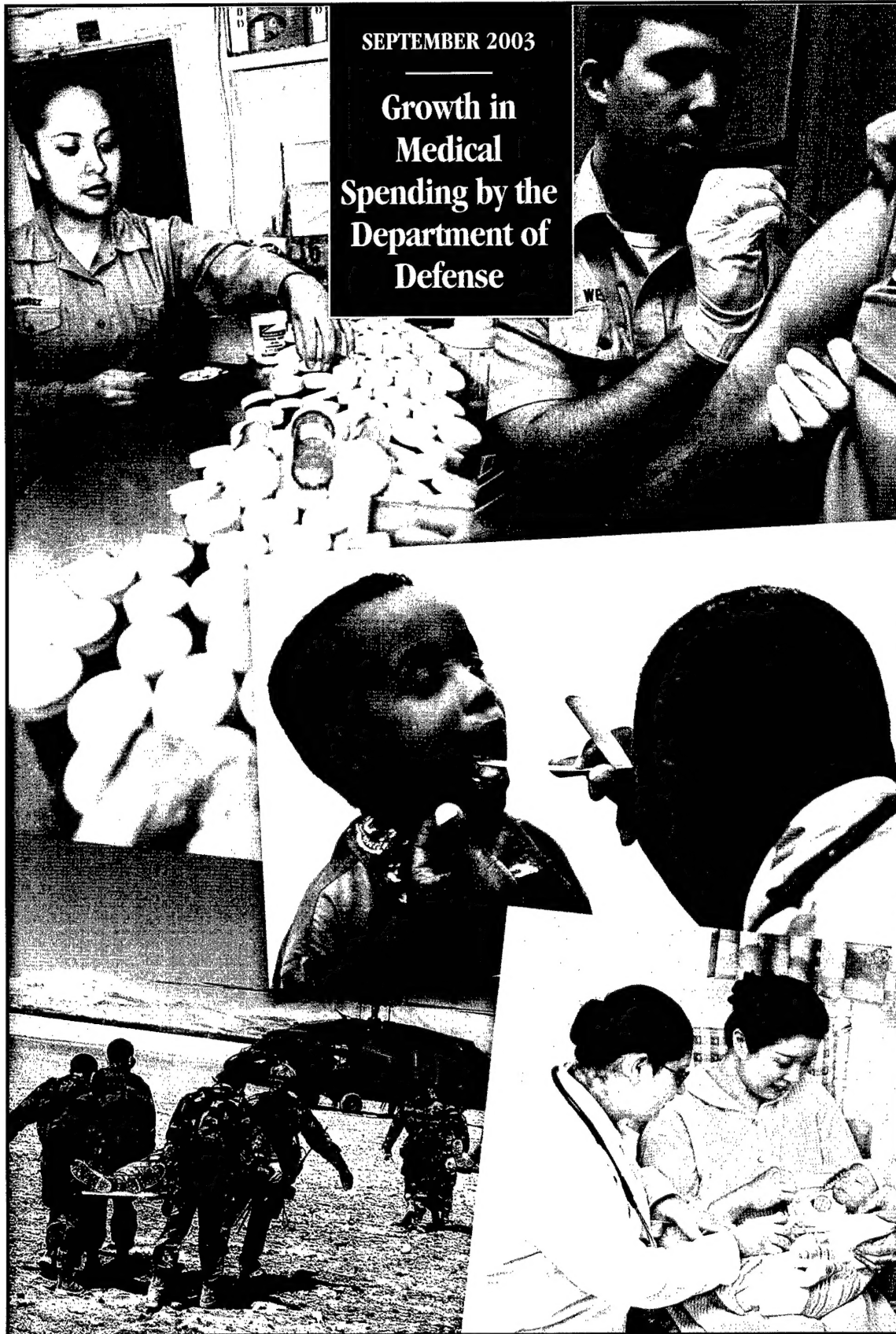


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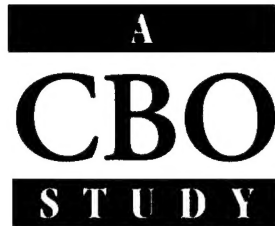
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SEPTEMBER 2003

**Growth in
Medical
Spending by the
Department of
Defense**

20031105 032



Growth in Medical Spending by the Department of Defense

September 2003

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Notes

Unless otherwise indicated, all years referred to in this study are fiscal years.

Numbers in the text and tables may not add up to totals because of rounding.

All dollar amounts are expressed in 2002 dollars (having been converted, when necessary, using the gross domestic product price deflator).

The photographs on the cover of this report appear courtesy of the Department of Defense. They were taken by Journalist 2nd Class Sybil McCarrol, U.S. Navy (top right); Tom Watanabe, for the U.S. Navy (bottom right); Senior Master Sgt. Dennis W. Goff, Air National Guard (bottom left); Photographer's Mate 2nd Class Steven Harbour, U.S. Navy (top left); and Cpl. Paula M. Fitzgerald, U.S. Marine Corps (center).

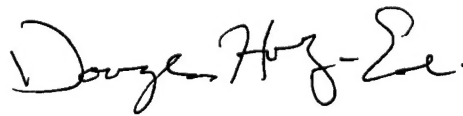


Preface

From fiscal year 1988 to 2003, the Department of Defense's (DoD's) spending on medical care almost doubled in real terms. That growth occurred despite large reductions in the size of the active-duty military force and a substantial reduction in the size of the military's own hospital system. This Congressional Budget Office (CBO) study—prepared at the request of the Chairman of the Senate Budget Committee—examines the reasons for those increases and considers directions for the future. Already, DoD's total spending on health care is more than half as large as its cash compensation. Looking forward, CBO's analysis examines how overall growth of health care costs in the economy could affect DoD's health care costs through 2020, as well how changes in benefits could do so. In keeping with CBO's mandate to provide objective, impartial analysis, this study makes no recommendations.

Allison Percy of CBO's National Security Division wrote the study under the general supervision of Deborah Clay-Mendez and J. Michael Gilmore. Sam Papenfuss of CBO's Budget Analysis Division prepared the cost estimates in Chapter 3 and wrote Appendix C under the general supervision of Jo Ann Vines and Peter H. Fontaine. Julie H. Topoleski of CBO's Health and Human Resources Division provided assistance with the projection methodology in Chapter 2. Carla Tighe Murray of the National Security Division helped review the manuscript for factual accuracy. Arlene Holen, Julie Lee, Robert P. Murphy, Carla Tighe Murray, Sam Papenfuss, Rachel Schmidt, Jo Ann Vines, and G. Thomas Woodward provided thoughtful comments on a draft of the study, as did external reviewer Paul F. Dickens.

John Skeen edited the study, and Christine Bogusz proofread it. Cindy Cleveland produced drafts of the manuscript, and Christian Spoor prepared the study for publication. Lenny Skutnik printed the initial copies, and Annette Kalicki prepared the electronic versions for CBO's Web site (www.cbo.gov).



Douglas Holtz-Eakin
Director

September 2003

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Summary

The Department of Defense (DoD) faces a growing burden in providing peacetime health care for military personnel, retirees, and their dependents and survivors—who all together number over 8 million. Adjusted for the overall rate of inflation in the U.S. economy, the department's annual spending on medical care almost doubled from 1988 to 2003, rising from \$14.6 billion to \$27.2 billion. Furthermore, because DoD cut the size of the active-duty force by 38 percent over that same period, medical spending per active-duty service member nearly tripled, rising from \$6,600 to \$19,600.¹ Medical spending rose from one-quarter to more than one-half of the level of cash compensation (defined as basic pay, the housing allowance, and the subsistence allowance), and it is likely to continue to increase.

DoD views many of its medical costs as unavoidable. The department argues that it must operate its own in-house system of health care providers and military medical treatment facilities to ensure that U.S. forces will have reliable, high-quality medical care in time of war. Moreover, DoD believes that in peacetime, it needs that in-house system, together with care purchased from the private sector, to provide the health care benefits necessary to attract and retain high-quality active-duty and reserve forces.

CBO's analysis addresses some of the questions raised by the trends in spending growth. What factors explain the historical growth in DoD's medical costs? If policies do not change, what levels of spending might be seen in the

future? What are the implications of current trends in military medical costs for the total costs of military personnel? How might various policy changes work either to suppress or accelerate growth in DoD's medical spending?

Factors Underlying Past Growth

Over half (56 percent) of the total growth in spending per active-duty service member from 1988 to 2003 can be attributed to national changes in health care costs generally—owing to greater use of technology, changes in the utilization of health care services, and higher medical prices (*see Summary Figure 1*). That growth reflects a trend that could continue. Another 41 percent of the observed growth can be attributed to events that are unlikely to recur. One was a shift in the mix of DoD's beneficiary population: the number of active-duty service members and their dependents fell substantially during the military drawdown after the Cold War while the number of retirees and their dependents grew—pushing up spending per active-duty service member. Another unique event was the introduction of accrual budgeting for the medical benefits of military retirees and their dependents who were eligible for Medicare. That accounting change (aimed at better capturing the full cost of labor) did not affect benefits but did raise DoD's budgets.

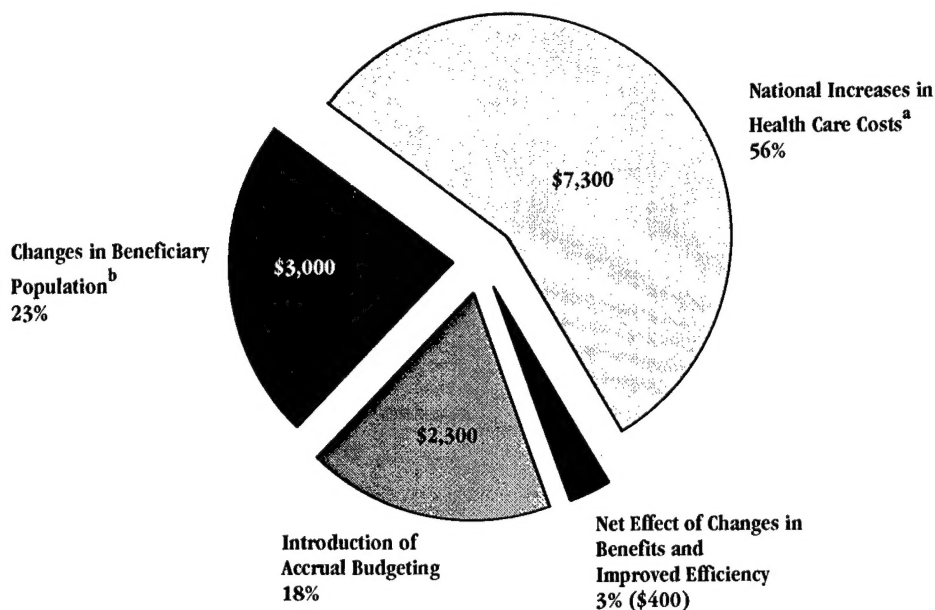
The remaining 3 percent of growth in spending derived from other changes within DoD's medical system. Although small, that figure derives from the net effect of several more substantial offsetting factors, including reduced access to care at military medical treatment facilities in the 1990s, improved efficiency with the in-

1. These figures are calculated as medical spending on all beneficiaries divided by the number of active-duty service members.

Summary Figure 1.

Factors Contributing to the Growth in the Department of Defense's Medical Spending per Active-Duty Service Member, 1988 to 2003

(2002 dollars)



Source: Congressional Budget Office.

Note: The Department of Defense's medical spending increased from \$6,600 per active-duty service member in 1988 to \$19,600 in 2003, or by a total of \$13,000.

a. Owing to the greater use of technology, changes in the utilization of health care services, and higher medical prices.

b. Consisting of a decrease in the number of active-duty military personnel and their dependents and an increase in the number of retirees and their dependents and survivors.

roduction of the TRICARE program, and new medical benefits provided since 2000. The most significant of those new benefits was the TRICARE For Life plan for Medicare-eligible retirees introduced in fiscal year 2002. CBO estimates that that program added \$3.0 billion to military health care spending in 2003.

Projections of Future Growth Under Current Policies

Because DoD is subject to many of the same factors that drive growth in per capita health care spending in the United States as a whole, CBO began its projections of the department's future medical spending by incorporating just those general influences—extending the department's

current policies, including the current size of the military. If DoD's medical spending (adjusted for projected shifts in the number and mix of beneficiaries) increases at the same rate as per capita medical spending (similarly adjusted) in the United States as a whole, it could grow from \$27 billion today to between \$40 billion and \$52 billion by 2020 (in 2002 dollars). That range translates to between \$29,000 and \$38,000 a year for each active-duty service member.

Medical spending is already substantially higher per dollar of cash compensation for members of the military than it is for federal civilian employees or private-sector workers. Although that fact is due in part to the early age at which military service members retire, it also reflects the

high rate at which DoD's beneficiaries utilize health care services. Unlike beneficiaries of health care plans offered by private employers, most of DoD's face few, if any, premiums, deductibles, or copayments.

If current policies remain unchanged, DoD's spending on health care per dollar of cash compensation could grow from 55 cents to between 64 cents and 84 cents by 2020 (see *Summary Figure 2*). To the extent that military members might prefer a compensation package that placed more emphasis on cash relative to medical benefits, that mix of compensation could reduce the quality of the force that DoD could attract and retain for a given compensation budget and increase the cost of military personnel relative to contractors and civilians.

Policy Changes and Future Spending

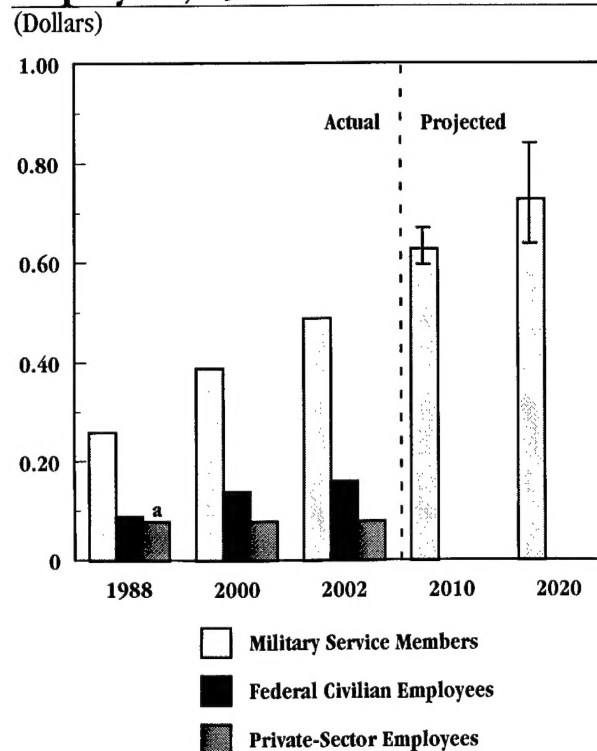
Although the same factors underlying national trends are likely to put pressure on DoD to increase its medical spending, that spending may not continue to rise in line with that in the United States as a whole. DoD's medical spending grew more slowly than national trends from 1988 to 2000 and much more quickly from 2000 to 2003. The markedly different rates of growth seen during those two periods illustrate the impact that changes in policies and benefits can have.

This analysis examines four policy changes and their potential effect on DoD's future medical spending. Two of the policies, drawn from trends in private-sector health care and a change in the military retirement system that introduced an element of choice, would slow the rate of growth by offering beneficiaries the opportunity to choose less-generous health coverage and receive some of the savings in cash.

The first would allow retiring service members to choose a cash bonus instead of TRICARE For Life coverage after age 65. The present discounted cost of TRICARE For Life at retirement for an individual who retires this year is \$172,000, a figure that rises to \$319,000 for someone who will retire in 2020. Even if service members received a bonus of only half of the present discounted value, many might prefer to take the cash in place of the benefit. The second policy change would create a "cafeteria plan" that would provide family members of active-duty personnel

Summary Figure 2.

Medical Spending per Dollar of Cash Compensation for Service Members and for Federal and Private-Sector Employees, 1988 to 2020



Source: Congressional Budget Office using information from the Department of Defense (for military service members), the Office of Personnel Management (for federal civilian employees' salaries and Federal Employees Health Benefits program premiums), and the Bureau of Labor Statistics (for comparable data on private-sector employees).

Note: Error bars represent high and low estimates (detailed in Chapter 2).

a. Based on 1991 data because earlier data are not available.

with a cash allowance that they could use to pay for any current TRICARE plan, a new low-option TRICARE plan, or coverage by a civilian employer. By 2020, those policy changes together would reduce DoD's annual medical spending by 3 percent, or \$1.5 billion, CBO estimates. At the same time, they would increase the options available to service members and their families.

However, such options that offer choice cannot by themselves halt the shift in the compensation package away

from cash and toward health care. Even if both of the options were adopted, DoD's spending on health care per dollar of cash compensation could still rise from 55 cents today to 70 cents by 2020. Maintaining the current ratio could require far-reaching changes, such as the introduction of premiums (which could reduce DoD's costs by encouraging families with access to plans offered by private employers to choose those plans) and imposing more copayments (which would bring down utilization rates). In the private sector, employers have relied on changes in health care benefits and on premiums, deductibles, and copayments to hold medical spending below nine cents per dollar of salaries and wages (as shown in Summary Figure 2).

The third and fourth policies examined in this study would increase the rate of growth in DoD's health budget by implementing new benefits that have been proposed (by lawmakers in current legislation and by advocacy groups) for reservists and for retirees under age 65. If DoD offered reservists full-time access to the TRICARE program, as considered in the third option, and expanded benefits for retirees under age 65, as described in the fourth option, DoD's medical spending could increase by 15 percent, or \$7 billion per year, by 2020. However, the size of the increase would depend crucially on the design of the benefits. If DoD simply helped the families of reservists pay the costs of maintaining their civilian coverage during mobilizations, spending would increase by only \$9 million per year by 2020 under peacetime conditions.

Historical Growth in the Department of Defense's Medical Spending

The Department of Defense (DoD) substantially increased its total medical spending from 1988 to 2003. Adjusted for the overall rate of inflation in the U.S. economy, DoD's spending on medical care almost doubled over that 15-year period, rising from \$14.6 billion to \$27.2 billion (see *Figure 1*).¹ Because the size of the active-duty force shrank, spending per active-duty service member rose even more rapidly, at a real annual growth rate of 7.5 percent, increasing from \$6,600 to \$19,600 (see *Figure 2*). Basic pay and other cash compensation spending did not keep pace, so DoD's medical spending rose from 26 cents for every dollar spent on cash compensation for military personnel in 1988 to 55 cents on the dollar in 2003.²

1. The Congressional Budget Office used DoD's 2003 *Future Years Defense Program*, as normalized by the Institute for Defense Analyses, as the data source for the department's medical spending from 1988 to 2003. "Medical spending" is defined as all expenses (including military personnel expenses) attributed to Defense Mission Category Code 323, "Medical," plus accrual payments for the health care benefits of Medicare-eligible retirees. Dollar amounts may differ somewhat from the Defense Health Program's budget documents. Spending for fiscal year 2003 was estimated in the data set and may not match actual outlays for the year.
2. This analysis focuses on cash compensation rather than total compensation. The compensation package provided to service members includes a wide variety of in-kind benefits whose value can depend on the service member's marginal tax rate and other factors. Another common metric for military pay is "regular military compensation," or RMC, which includes cash compensation and the value of housing and subsistence allowances plus the tax

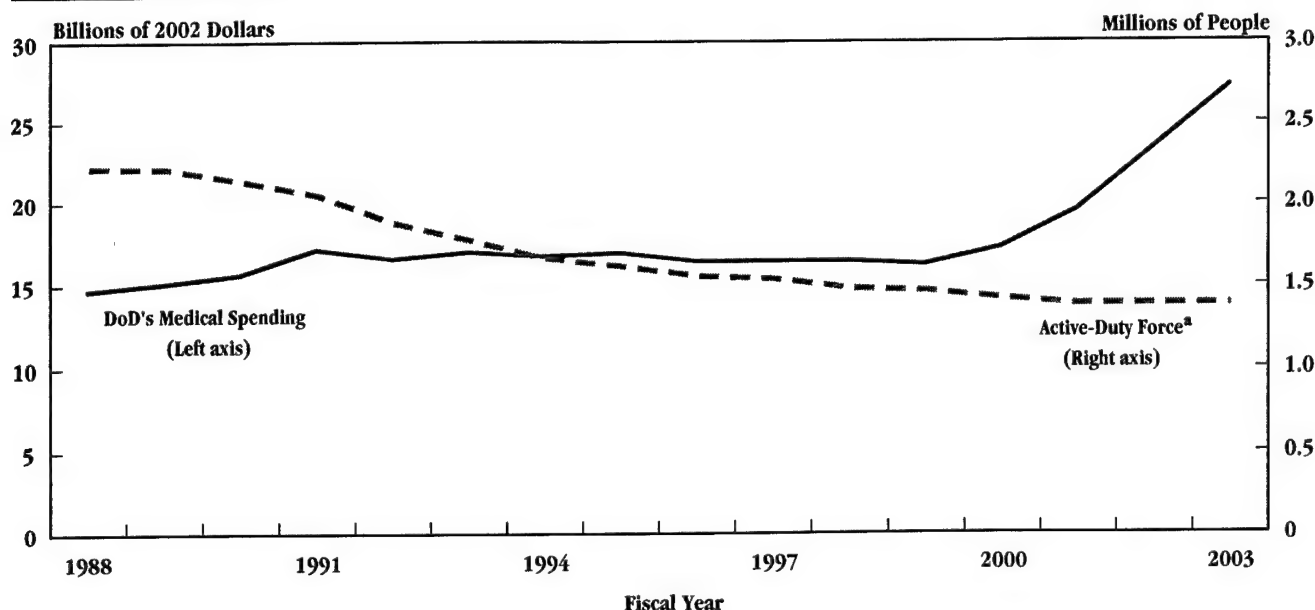
DoD is responsible for providing medical care and coverage for over 8 million beneficiaries. It does so through the TRICARE program, which combines hundreds of military medical treatment facilities with several regional networks of civilian health care providers. Although the primary purpose of the system is to ensure a healthy active-duty force capable of performing critical national security missions, TRICARE provides coverage for a wide variety of eligible beneficiaries: not only active-duty service members, but also military retirees and mobilized reservists, along with their families and survivors. The program offers several different health plans, including TRICARE Prime (organized as a health maintenance organization), TRICARE Extra (set up as a preferred provider organization), and TRICARE Standard (a fee-for-service plan). Also, military retirees and their family members who are eligible for Medicare can access a new TRICARE For Life benefit that complements Medicare's coverage. (See *Appendix A* for additional details about DoD's medical coverage.)

While treatment for combat injuries and medical evacuation constitute a part of DoD's medical program, peacetime care accounts for the overwhelming majority of DoD's medical spending. In 2003, spending on programs that are specific to military needs and have no counterparts in private-sector civilian health plans made up only 3 per-

advantage arising from the fact that the allowances are not subject to income or payroll taxes. The Congressional Budget Office estimates that medical benefits grew from 20 cents per dollar of RMC to 43 cents per dollar of RMC between 1988 and 2003.

Figure 1.

The Department of Defense's Historical Medical Spending and the Size of the Active-Duty Force



Source: Congressional Budget Office based on information from the Department of Defense's 2003 *Future Years Defense Program* (for medical spending); *Department of Defense Budget for Fiscal Years 2004/2005: Military Personnel Programs* (for the 2003 accrual payment included in medical spending); and the Defense Enrollment Eligibility Reporting System and Managed Care Forecasting and Analysis System (for the size of the active-duty force).

a. Excluding mobilized and full-time members of the Reserves and National Guard.

cent (\$900 million) of the department's total medical spending.³ However, many of the resources used to provide peacetime care also contribute to wartime readiness.

Some critics view the growth in DoD's medical spending as an indication that the department needs to manage its health care dollars more efficiently, increasing the amount of health care provided per dollar. But this analysis finds that however efficient or inefficient DoD may be in using its health care resources, the observed growth in spending (adjusted for changes in the department's accounting methods and changes in the size and mix of DoD's popu-

lation of beneficiaries) has been consistent with the growth in per capita health care spending in the U.S. population as a whole over the past 15 years. However, the rate of growth over shorter periods of time has been closely tied to policy changes affecting benefits.

Growth in per Capita Health Care Spending for the U.S. Population

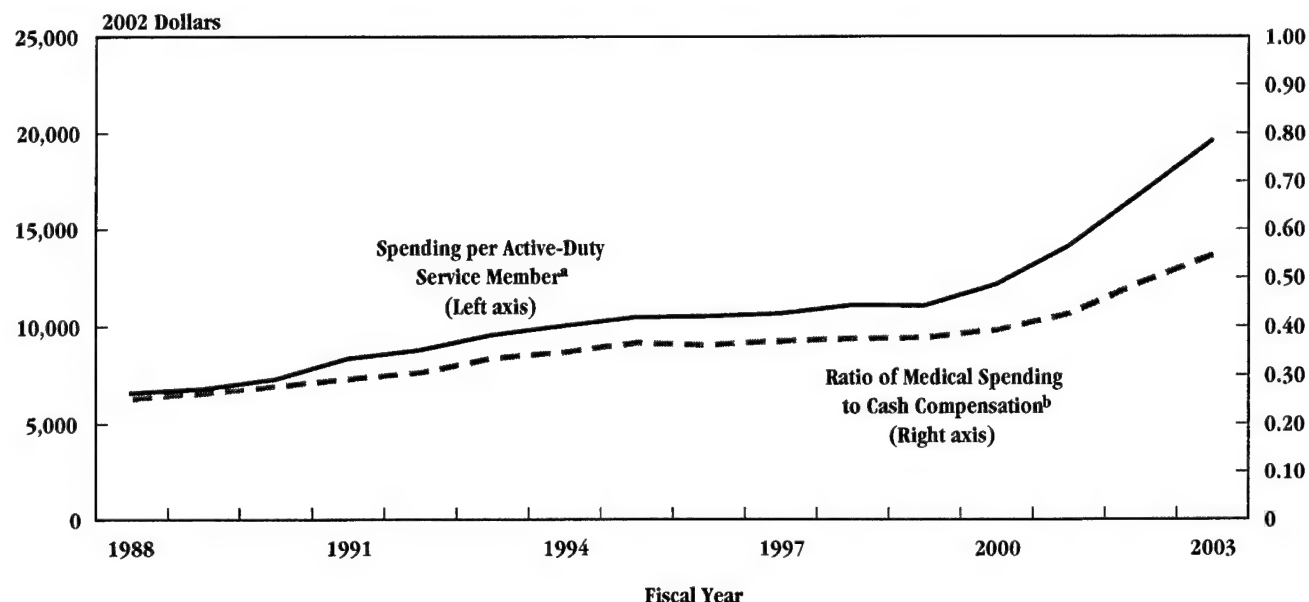
In the United States as a whole, per capita health care expenditures (adjusted for changes in the population in terms of age and sex) increased by 76 percent in real terms from 1988 to 2003.⁴ That growth reflects technological improvements, new medical treatment standards, different patterns of utilization, and increases in the prices of medi-

3. That amount reflects most of the spending on the Consolidated Health Support Budget Activity Group, which provides for health exams for recruits, military public/occupational health, veterinary services, the aeromedical evacuation system, the Armed Forces Institute of Pathology, and health services unique to the military.

4. That increase reflects real growth after allowing for the general rate of price inflation in the economy.

Figure 2.

The Department of Defense's Historical Medical Spending per Active-Duty Service Member and Relative to Cash Compensation, 1988 to 2003



Source: Congressional Budget Office using information from the Department of Defense's 2003 *Future Years Defense Program* (for medical spending); *Department of Defense Budget for Fiscal Years 2004/2005: Military Personnel Programs* (for the 2003 accrual payment included in medical spending); the Defense Enrollment Eligibility Reporting System and Managed Care Forecasting and Analysis System (for the size of the active-duty force); and DoD's 1996 Military Compensation Background Papers and recent budget documents (for cash compensation).

a. For the purposes of this figure, mobilized and full-time reservists have not been counted as part of the active-duty force.

b. Cash compensation includes basic pay, the basic allowance for housing, and the basic allowance for subsistence.

cal goods and services that exceeded the overall rate of price inflation in the economy.

DoD is subject to many of the same pressures that contribute to rising medical costs in the economy. Technologies and standards of care in DoD facilities are similar to those in civilian health facilities. Moreover, DoD spends approximately \$5 billion annually on Managed Care Support contracts with private insurers who oversee the civilian providers in the TRICARE system, and much of the remainder of its budget pays for supplies and pharmaceuticals purchased from the same firms used by private health care providers. Increases in the cost of medical personnel in the civilian economy may also affect what DoD must pay to attract and retain qualified personnel in the military. In the absence of changes in benefits, those connections with the private sector could tend to push

DoD's spending up at the same rate as the cost of care in U.S. society as a whole.

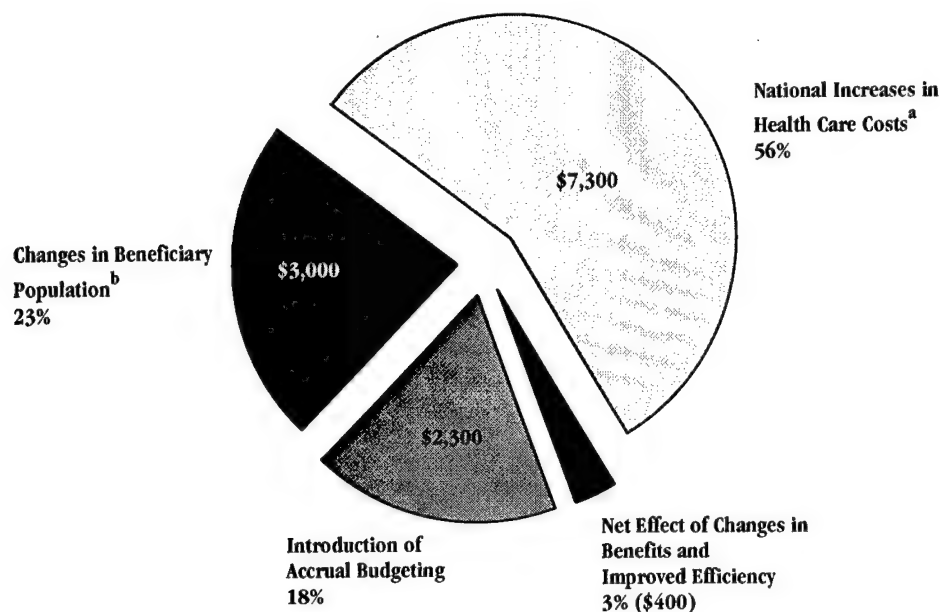
If those factors raised the cost of DoD's care by the same percentage as the cost of care in the country as a whole (with adjustments included for changes in the populations of beneficiaries), they could account for \$7,300, or 53 percent, of the observed growth in the department's medical spending per active-duty service member between 1988 and 2003 (see Figure 3).

One-Time Occurrences Contributing to Growth in DoD's Medical Spending

Two specific occurrences account for roughly 40 percent of the \$13,000 growth in DoD's health care spending per active-duty service member between 1988 and 2003. First,

Figure 3.**Factors Contributing to the Growth in the Department of Defense's Medical Spending per Active-Duty Service Member, 1988 to 2003**

(2002 dollars)



Source: Congressional Budget Office.

Note: The Department of Defense's medical spending increased from \$6,600 per active-duty service member in 1988 to \$19,600 in 2003, or by a total of \$13,000.

a. Owing to the greater use of technology, changes in the utilization of health care services, and higher medical prices.

b. Consisting of a decrease in the number of active-duty military personnel and their dependents and an increase in the number of retirees and their dependents and survivors.

the number of military retirees and dependents eligible for health benefits increased sharply relative to the number of active-duty personnel because of the decision to dramatically decrease the size of the active-duty force at the end of the Cold War. Second, the introduction of accrual budgeting in fiscal year 2003 caused a jump in DoD's spending that reflects a change in the way the department's obligations are tracked but not a change in the benefits that it owes to beneficiaries.

Growth in Numbers of Military Retirees and Dependents Relative to Active-Duty Personnel

In 1988, the population eligible for DoD's medical benefits included 3.1 non-active-duty individuals for each

active-duty service member.⁵ By 2003, however, there were 4.7 eligible non-active-duty individuals for each active-duty service member. That increase reflects both the decline in the size of the active-duty force at the end of the Cold War (known as the "drawdown") and the growth in the size of the population of military retirees as the first cohorts to enter the military under the All-Volunteer Force became eligible for military retirement.

5. Full-time and mobilized reservists and their families are not included in this calculation. If they were included, the number of non-active-duty beneficiaries per service member would be 3.0 in 1988 and 4.3 in 2003.

Active-duty service members can retire after 20 years of service and receive both a pension and lifetime access to DoD's medical system for themselves and their dependents. Most of those who retire are between 38 and 45 years of age. About 30 percent to 40 percent of officers and only 10 percent to 20 percent of enlisted personnel ever become eligible for military retirement.⁶ Because both the pension and health care coverage are provided immediately upon retirement and the retirement age is quite young, the cost of those benefits is high compared with the compensation received during active-duty service.

During the drawdown, the number of active-duty personnel decreased from over 2.2 million to under 1.4 million. At the same time, the number of military retirees in the beneficiary population rose from 1.6 million to nearly 2 million. Since the end of the drawdown, the ratio of beneficiaries to active-duty personnel has stabilized, however, and is not expected to contribute to future growth in spending per active-duty service member.

Overall, changes in the number and mix of beneficiaries (in terms of age, sex, and military status) accounted for \$3,000, or nearly one-quarter of the growth in the department's medical spending per active-duty service member between 1988 and 2003 (see *Figure 3*). That estimate takes into consideration how health care use varies by age and sex, as well as differences in the extent to which active-duty and retired individuals of different ages rely on DoD's health care. Older individuals, on average, consume substantially more health care resources than younger individuals do. Counterbalancing that, however, is the fact that military retirees, on average, rely less on DoD for their care and more on civilian employers and Medicare.

The Introduction of Accrual Budgeting

A second factor that increased DoD's medical spending over this period was the introduction of accrual funding for the benefits of military retirees eligible for Medicare. Under accrual budgeting, DoD pays for the cost of medi-

cal benefits provided in retirement as those benefits are earned by active-duty service members, rather than as the benefits are paid to those who are already retired.⁷ (See *Box 1* for additional details.)

Because health care costs are expected to grow faster than overall inflation, the cost of the benefits that accrue to those on active duty in 2003 is expected to be about \$3.2 billion greater than the cost of benefits provided to retirees. As a result, shifting to the new accounting system has resulted in a one-time increase in DoD's spending, although total federal outlays for medical care and the actual level of resources used to provide care for Medicare-eligible beneficiaries have not been affected by the accounting change. Because of the shift, DoD's spending per active-duty service member rose by \$2,300 in 2003 over what it otherwise would have been, explaining 18 percent of the growth seen between 1988 and 2003 (see *Figure 3*).⁸

Other Factors Affecting the Pattern of Growth in DoD's Medical Spending

Both legislation and DoD's policies also played a role in increasing the department's medical spending. The Congressional Budget Office's (CBO's) analysis attributes only 3 percent of the total growth in spending per active-duty service member to changes in benefits and efficiency. That small percentage, however, represents the net effect of several important offsetting factors. Within it are decreases in spending that resulted from restructuring the military health system during the 1990s by closing or

7. See Congressional Budget Office, *Accrual Budgeting for Military Retirees' Health Care* (March 2002).

8. DoD paid \$7.5 billion into the Medicare-Eligible Retiree Health Care Fund in 2003. However, the department received outlays of \$4.3 billion from the fund. Of that, \$1.3 billion went to military medical treatment facilities to pay for care received there by Medicare-eligible retirees and their dependents. Those costs were previously covered under the Defense Health Program's budget. The remaining \$3.0 billion purchased care under the TRICARE For Life and TRICARE Senior Pharmacy programs (the latter of which provides Medicare-eligible military retirees and dependents with an expanded pharmacy benefit).

6. Beth J. Asch, Richard Johnson, and John T. Warner, *Reforming the Military Retirement System* (Santa Monica, Calif.: RAND, 1998).

Box 1.**Accrual Budgeting for Retirees' Health Benefits**

In an accrual budget, the costs of deferred compensation such as pensions and retirees' health care are recognized during the years in which the employees are working, not when the benefits are actually paid. Accrual budgeting has become increasingly important in the federal budget because it provides better information about the full cost of labor and gives decisionmakers better incentives to use labor cost-effectively.¹

In 2002, the Department of Defense (DoD) introduced the TRICARE For Life program, a new benefit for Medicare-eligible military retirees that pays most of the copayments and deductibles not covered by Medicare. In the first year of that program, benefits were paid out of the annual budget of the Defense Health Program. Beginning in 2003, however, payments for benefits are being made from the Medicare-Eligible Retiree Health

Care Fund. The health care that those beneficiaries receive at military medical treatment facilities is also paid for by that fund.

Each year, DoD pays into the fund an amount that is calculated on the basis of the current number of active-duty and reserve personnel. An independent board of actuaries sets the amount of those payments (known as "normal cost payments") so that, when invested in Treasury securities, they will fully fund the future benefits earned by the people currently in uniform. The costs of medical benefits for current retirees and any benefits for personnel now in uniform that are attributable to military service before 2003 become an unfunded liability of the fund. The Treasury, rather than DoD, is responsible for making annual payments into the fund to amortize that liability of over \$400 billion; in 2003, the amortization payment was \$14 billion. The Treasury also covers financial losses or gains to the fund resulting from unanticipated changes in benefits and interest rates.

1. Congressional Budget Office, *Accrual Budgeting for Military Retirees' Health Care* (March 2002).

downsizing many facilities, savings associated with the introduction of managed care in the form of TRICARE Prime, and the cost of the TRICARE Senior Pharmacy and TRICARE For Life benefits introduced in 2001 and 2002, respectively.⁹

DoD's spending grew less rapidly than might have been predicted on the basis of national health expenditures from 1988 through 2000 but much more rapidly after that (see *Figure 4*). The differences between growth in DoD's medical spending and that in civilian health care spending can be seen most easily if the department's spending is

expressed not relative to the number of active-duty personnel but relative to the number of eligible DoD beneficiaries, adjusted for changes over time in the mix of the population by age, sex, and military status. To make that adjustment, CBO used information on how health care usage varies by age and sex and how beneficiaries' reliance on DoD's system varies by military status to convert the actual population of beneficiaries into a number of full-time-equivalent beneficiaries, with the cost of supporting an 18-to-44-year-old active-duty male used as the base. (See *Appendix B* for a more detailed discussion of CBO's analysis.)

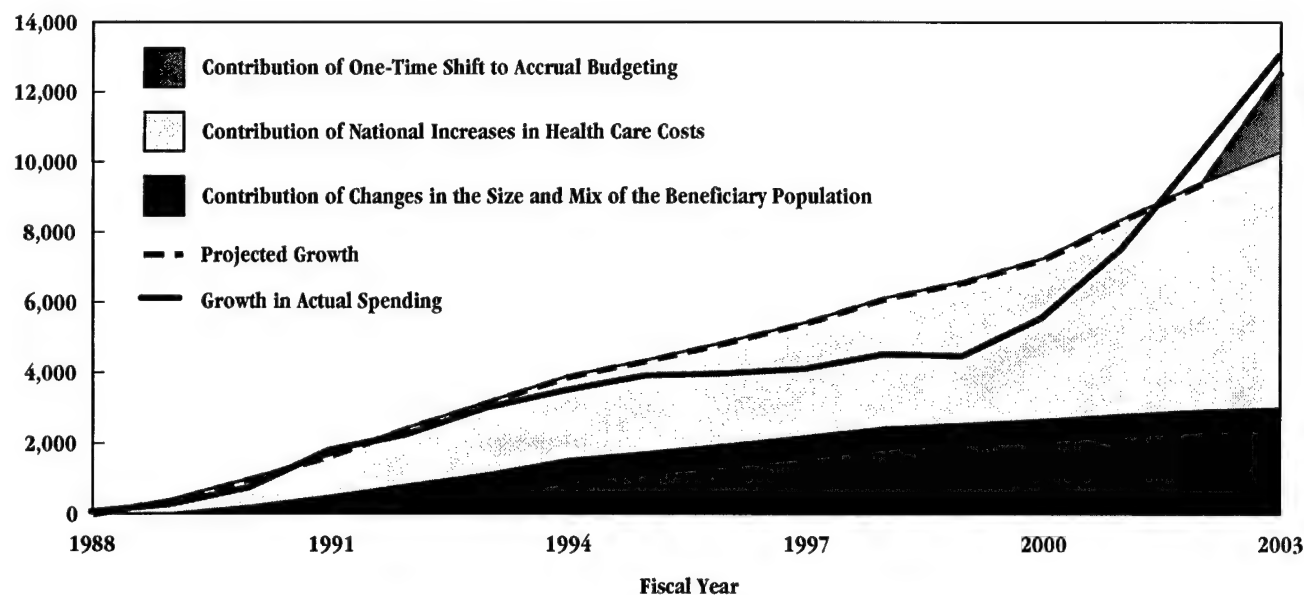
Growth in Spending Between 1988 and 2000

Between 1988 and 2000, DoD's health care spending per full-time-equivalent beneficiary grew at an annual rate of 2.3 percent, or from \$1,300 to \$1,700. That is well below the 3.4 percent annualized growth rate in per capita health care spending seen for the United States as a whole (adjusted for the age and sex mix of the U.S. population) during that same period.

9. That cost reflects a \$3 billion increase in spending that would have been required had DoD funded the new TRICARE For Life benefits (including TRICARE Senior Pharmacy) without shifting to an accrual budget. It is in addition to the \$3.2 billion increase in DoD's budget that is due to the decision to fund the health benefits of Medicare-eligible retirees on an accrual basis starting in fiscal year 2003.

Figure 4.**Actual and Projected Growth in the Department of Defense's Medical Spending per Active-Duty Service Member, 1988 to 2003**

(2002 dollars)



Source: Congressional Budget Office.

Note: Calculations for this figure include DoD's medical spending on all types of beneficiaries divided by the number of active-duty service members. For the purposes of this figure, mobilized and full-time reservists have not been counted as part of the active-duty force.

One explanation for the lower rate of growth in DoD's spending is that the department may have increased the efficiency of its health care system relative to that in the United States as a whole during that period. During the 1990s, DoD gradually made the managed health care program TRICARE Prime available to the families of active-duty personnel as well as retirees and their dependents not eligible for Medicare. Even if DoD may simply have been catching up with managed care innovations that had already been introduced in the private sector, the introduction of TRICARE Prime could have helped constrain DoD's spending increases during this period.

Another reason that DoD's spending may have grown more slowly is that contract disputes and a backlog of unresolved change orders delayed some payments to the department's regional Managed Care Support contractors. Those disputes about contracts that went into effect between 1995 and 1998 were settled in 2001 for a total

of \$2.1 billion. The delay pushed those costs into the future, leading to an understatement of DoD's actual cost growth between 1988 and 2000.

In addition, the end of the Cold War brought many base closures and hospital consolidations that decreased the number of DoD's in-house medical treatment facilities. From 1990 to 2001, the number of beds at such facilities dropped by 74 percent, bed-days by 76 percent, and outpatient visits by 36 percent.¹⁰ On the one hand, the changes made DoD's system of in-house treatment facilities more cost-effective, allowing the department to avoid the cost of maintaining facilities that it no longer required for its wartime mission. On the other hand, they amounted to a de facto decline in the level of benefits

10. According to data obtained from DoD's Office of the Assistant Secretary of Defense for Health Affairs, May 2, 2002.

provided to Medicare-eligible retirees, many of whom had difficulty obtaining care at military medical treatment facilities on a space-available basis. The increasing difficulty that retirees and their dependents experienced in obtaining access to military medical treatment facilities is reflected, in part, in a decline in the degree to which they relied on DoD for health care during that period. (See Figure B-2 in Appendix B for more details.)

Growth in Spending from 2000 to 2003

In contrast to the period from 1988 to 2000, the period since then has seen DoD's spending per full-time-equivalent beneficiary grow much more rapidly than what might have been expected given the rate of growth in real per capita health care spending in the United States as a whole. For DoD, spending per full-time-equivalent beneficiary rose from \$1,700 in 2000 to \$2,300 in 2003—reflecting an annual growth rate of 11.3 percent. For the United States as a whole, that rate (adjusted for shifts in the mix of the population by age and sex) was 5.6 percent.¹¹

More than a fifth of that more rapid growth is explained by DoD's efforts to eliminate the backlog of payments owed to contractors, mentioned earlier. Nearly a third of the growth in DoD's medical spending, however, might be attributed to policy changes that increased the level of benefits available to beneficiaries (see Table 1). In the future, trends in DoD's medical spending may also depend heavily on what, if any, changes in benefits take place.

Comparisons with Other Employers' Spending on Health Care

Although the growth in DoD's medical spending overall from 1988 to 2003 is consistent with broader trends in health care costs, DoD's experience is not the same as other employers'.

11. For the purpose of comparing DoD's health care costs with national trends in health care costs, this discussion excludes the effect of DoD's switch to accrual budgeting. If the cost of the change to accrual budgeting had been included, the annual rate of growth in DoD's medical spending per full-time-equivalent beneficiary would have been 16.1 percent, increasing from \$1,700 in 2000 to \$2,600 in 2003.

Trends in Health Care Benefits of Private Employers

As per capita health care costs rose in the United States, many private employers sought to restrain spending on health benefits for their employees by shifting costs to them—whether by dropping health insurance coverage, requiring higher contributions from employees toward premiums, shifting to preferred provider plans and away from more costly fee-for-service plans, or offering plans with higher deductibles and copayments.

The percentage of employers offering coverage to current and retired employees has declined in recent years. Between calendar year 1988 and calendar year 1997, for example, the percentage of medium-sized and large firms offering medical benefits to current employees fell from 90 percent to 76 percent.¹² According to the Employee Benefit Research Institute, the percentage of companies reporting that they provide medical benefits to retirees declined from 20 percent in calendar year 1997 to 11 percent today and is expected to continue to fall.¹³ In addition, among those firms that continue to offer coverage to current employees, more are requiring employees to contribute toward the premium for single coverage. In 1988, 56 percent of firms offering health insurance coverage paid the entire premium for employees choosing single coverage. By 1997, that figure had fallen to 31 percent.¹⁴ Moreover, employees choosing family coverage have faced additional costs as well. The average premium contribution required by employers for family coverage increased in real terms by 28 percent between calendar years 1996 and 2002.¹⁵

The costs faced by most employees for deductibles and copayments also rose. On average, private-sector employ-

12. Bureau of Labor Statistics, National Compensation Survey—Benefits, available at www.bls.gov/ncs/ebs/home.htm.

13. Paul Fronstin and Dallas Salisbury, *Retiree Health Benefits: Savings Needed to Fund Health Care in Retirement*. Employee Benefit Research Institute Issue Brief (February 2003).

14. Bureau of Labor Statistics, National Compensation Survey—Benefits.

15. *The Kaiser Family Foundation and Health Research and Education Trust Employer Health Benefits 2002 Survey* (Menlo Park, Calif: Kaiser Family Foundation, 2002).

Table 1.

Estimated Contributions to Growth in the Department of Defense's Medical Spending per Full-Time-Equivalent Beneficiary

(In 2002 dollars)

	1988-2000	2000-2003	Total, 1988-2003
Increases in National Health Expenditures per Capita	637	337	974
Shift to Accrual Budgeting	n.a.	311	311
New Benefits			
TRICARE for Life	n.a.	290	290
TRICARE Prime Remote ^a	n.a.	5	5
Elimination of copayments ^b	n.a.	<u>4</u>	<u>4</u>
Subtotal	n.a.	299	299
Delayed Payments to TRICARE Contractors ^c	-206	206	0
Reduction in Access to Military Medical Treatment Facilities, Increased Efficiency, and All Other Factors ^d	<u>-37</u>	<u>-211</u>	<u>-248</u>
Total Change in DoD's Medical Spending	394	942	1,336

Source: Congressional Budget Office.

Note: n.a. = not applicable.

a. For families living in remote areas not adequately served by TRICARE Prime.

b. For family members of active-duty personnel enrolled in the TRICARE Prime plan.

c. Reflects the settlement of contract disputes between the Department of Defense and its regional Managed Care Support contractors for services provided under the TRICARE program since the contracts started in 1995. Those contract disputes were settled for a total of \$2.1 billion in 2001.

d. The amounts shown are the residuals after all known factors contributing to cost increases and cost decreases have been accounted for.

ees in preferred provider plans have faced a 37 percent real increase in their deductibles since 1996. The copayments charged by health maintenance organizations for a visit to a physician increased by 12 percent in real terms.¹⁶

In part as a result of those changes in employees' premiums, copayments, and deductibles, the ratio of firms' spending on medical benefits to spending on salaries and wages has grown little in the past 10 to 15 years (see Figure 5), fluctuating from 8.3 percent in calendar year 1991 (the first year for which data from the Bureau of Labor Sta-

tistics are available), to 7.5 percent in 2000, to 8.4 percent at the end of 2002.¹⁷

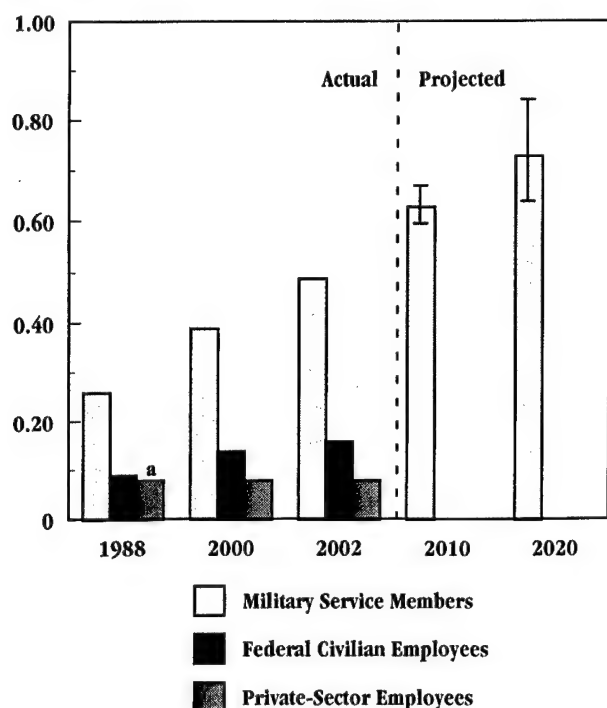
The extent to which changes in the number of hours worked by employees and in the number, age, and sex of covered beneficiaries contributed to the increase in spending in the private sector is not known, making comparisons with DoD's spending difficult. Nonetheless, as described above, DoD's spending on health care per active-duty service member increased by \$13,000 between 1988 and 2003, at an annualized growth rate of 7.5 percent. Even if the effects of the introduction of accrual

16. *The Kaiser Family Foundation Employer Health Benefits 2002 Survey*. Although private-sector employees in fee-for-service plans (similar to TRICARE Standard) experienced flat or decreasing deductibles, only 5 percent of private-sector employees were in such plans.

17. Bureau of Labor Statistics, National Compensation Survey—Compensation Cost Trends, available at www.bls.gov/ncs/ect/home.htm.

Figure 5.
Medical Spending per Dollar of Cash Compensation for Service Members and for Federal and Private-Sector Employees, 1988 to 2020

(Dollars)



Source: Congressional Budget Office using information from the Department of Defense (for military service members); Office of Personnel Management (for federal civilian employees' salaries and Federal Employees Health Benefits program premiums); and the Bureau of Labor Statistics (for comparable data on private-sector employees).

Note: Error bars represent high and low estimates (detailed in Chapter 2).

a. Based on 1991 data because earlier data are not available.

budgeting and changes in the beneficiary population were excluded, medical spending would still have grown by \$7,700 per active-duty service member over that period, at an annual rate of 5.3 percent. That increase alone would have caused medical costs to rise from 26 cents for every dollar of cash compensation in 1988 to 40 cents in 2003.

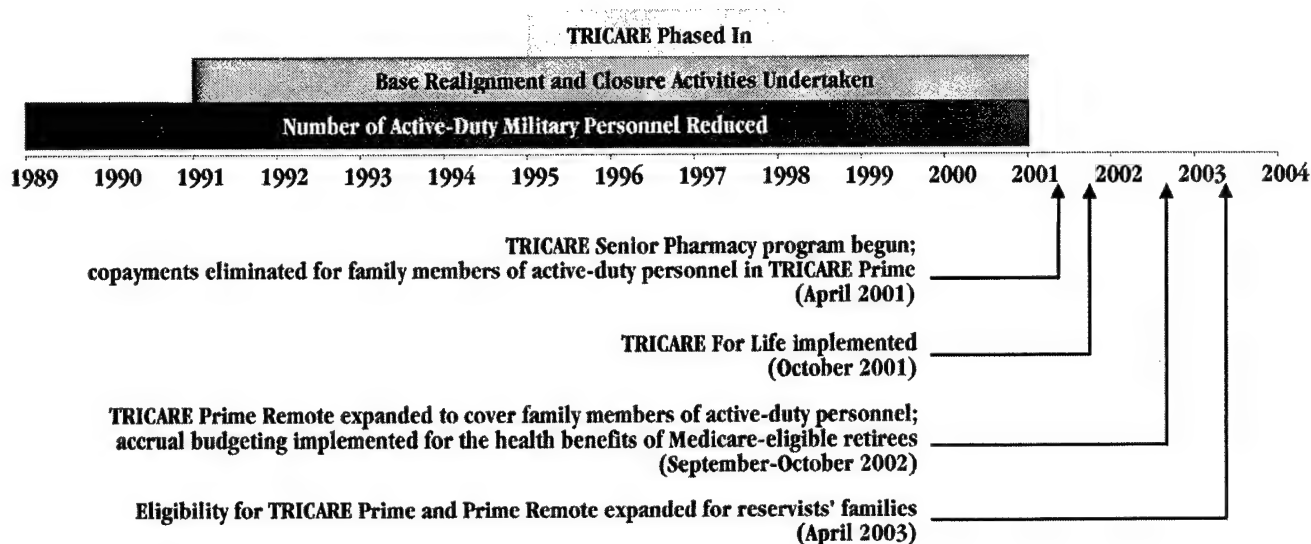
Trends in Military Health Care Benefits

Although DoD has adopted some of the same practices as private employers—for example, in its introduction of TRICARE Prime, a managed care program—the trend in DoD has generally been toward greater coverage and lower copayments and deductibles. (Figure 6 provides a timeline of changes in DoD medical coverage.) Families of active-duty personnel using TRICARE Prime pay no premiums or deductibles for services received from military medical treatment facilities or from TRICARE network providers, and the 2001 National Defense Authorization Act eliminated nearly all copayments for those users.¹⁸ Although retirees not eligible for Medicare must pay a small annual enrollment fee to participate in TRICARE Prime, inflation has reduced the real cost of the fees—\$230 for an individual and \$460 for a family—by 12 percent since 1995. Inflation since 1995 has also taken 12 percent off the real cost of the deductibles paid by the active-duty families using TRICARE Extra or Standard, DoD's preferred provider organization and fee-for-service plans, respectively. Other increases in benefits and coverage include the introduction of TRICARE For Life and TRICARE Prime Remote, a plan designed to reduce the out-of-pocket costs faced by families living in remote areas not adequately served by TRICARE Prime.

Government Spending on Health Care for Federal Civilian Employees

The rise in military health care costs relative to cash compensation during the 1990s, although not typical for private-sector employees, is closer to trends in federal health care spending for civilian employees. Inflation-adjusted spending by the federal government on health care benefits per civilian employee rose at an annual rate

18. Those charges were eliminated in order to improve customer satisfaction with TRICARE Prime and to make the benefit equal for people who see civilian providers and those who see military providers. Copayments and deductibles still apply for care provided outside the network. See "TRICARE Eliminates Prime Co-pays for Family Members," Military Health System News Release No. 01-05, February 6, 2001, available at www.tricare.osd.mil/newsreleases/News2001_005.htm.

Figure 6.**Timeline of Events for the Department of Defense's Medical Coverage**

Source: Congressional Budget Office.

of 6.1 percent between calendar years 1988 and 2003 (unadjusted for shifts in the age and sex of the population of civilian employees). That rate outpaced increases in wages per civilian employee, so government spending on health benefits as a percentage of salaries rose from 8.7 percent in 1988 to 16.0 percent in 2002 (*see Figure 5*).¹⁹

19. CBO's analysis is based on data provided by the Office of Personnel Management.

Despite that increase, spending on medical benefits per dollar of cash compensation has been much higher for the military than for either civilian federal employees or private-sector workers. That difference is partly due to the earlier retirement age for the military population: members of the military who serve 20 years will qualify for lifetime medical benefits for themselves and their dependents, and most retiring service members are in their 40s, as compared to most retirees in government or the private sector, who are generally at least 55 years old and often over 60 at retirement.

Projections of DoD's Future Medical Spending Under Current Policies

The Congressional Budget Office projected future spending assuming no change in the Department of Defense's policies and using low, midrange, and high estimates of health care cost growth. CBO's midrange estimates assume that DoD's costs per beneficiary grow at the real annual rate projected for per capita health spending in the United States as a whole (after adjustments for changes in the distribution of the population in terms of age and sex) and that DoD spends enough to keep the level of benefits the same.¹ CBO also projected both low and high estimates using growth rates that were 30 percent lower and higher, respectively, than the midrange assumptions. CBO chose that range because it falls within the range of error of previous government projections of health care cost growth (*see Box 2*).

Under the midrange assumptions, DoD's projected medical spending (including accrual payments) rises from \$27 billion in 2003 to almost \$46 billion in 2020—reflecting a real increase of 68 percent. If costs grow at rates that are 30 percent lower each year than those used in the midrange estimates, total spending could reach only

\$40 billion by 2020—an increase of 46 percent. If, however, costs grow at rates that are 30 percent higher than those in the midrange estimates, total spending could reach \$52 billion by 2020—an increase of 93 percent. Thus, under the high-range estimates, medical spending could approach the level of spending on cash compensation by 2020.²

Midrange Estimates

For its midrange estimates, CBO assumed that the accrual funds would grow at the same rate as that projected by DoD's actuaries—6.25 percent in nominal terms, or approximately 4.1 percent real growth in accrual payments

1. In deriving its estimates, CBO used projections of national health expenditures through 2010 made by the Office of the Actuary, Centers for Medicare and Medicaid Services, Department of Health and Human Services ([see cms.hhs.gov/statistics/nhe/projections-2002/highlights.asp](http://cms.hhs.gov/statistics/nhe/projections-2002/highlights.asp)). For the years after 2010, CBO assumed that per capita growth in those expenditures would begin to decrease toward an ultimate rate of growth 1 percentage point above the growth in per capita gross domestic product.

2. Using 2003 spending levels as the base, CBO estimated growth in DoD's medical spending per beneficiary and multiplied that estimate by the projected beneficiary population each year. CBO projected the growth of DoD's accrual payments into the Medicare-Eligible Retiree Health Care Fund at the rate of growth anticipated by DoD's Board of Actuaries. For population projections through 2009, CBO used figures from DoD's Managed Care Forecasting and Analysis System (MCFAS) database. For the years after 2009, CBO assumed that the size of the active-duty force and the number of reservists would remain fixed, as would the number of dependents of those personnel. CBO projected the population of retirees, dependents of retirees, survivors, and others through 2020 by extending the relevant average growth rates of 2007 through 2009 in MCFAS. In projecting the growth of cash compensation, CBO used DoD's budget projections through 2007 and assumed that thereafter cash compensation would grow by 1.1 percent annually in real terms, reflecting CBO's projection for the employment cost index.

Box 2.**Choosing a Range for Future Growth Projections**

The Congressional Budget Office's (CBO's) midrange projections hinge on the assumption that the Department of Defense's health costs will rise at about the same rate as that projected for civilian medical spending. However, that growth for civilian medical spending is uncertain. For that reason, CBO prepared low and high estimates using growth rates both above and below the rates assumed in the midrange estimates. In the case of spending on beneficiaries under 65, CBO's approach includes growth rates that are 30 percent below and 30 percent above the midrange rates. For the accrual charges funding benefits for Medicare-eligible beneficiaries, the low-growth estimate is 2.9 percent, and the

high-growth estimate is 5.3 percent—30 percent above and below the midrange growth rate of 4.1 percent.

In order to assess whether that range was reasonable, CBO examined 10-year projections made by the Department of Health and Human Services in the late 1980s and early 1990s. CBO found that those projections were anywhere from 45 percent below actual growth to 65 percent above (*see the table below*). In this analysis, because CBO is projecting spending over a longer period (the 17 years from 2003 to 2020), plus or minus 30 percent seemed a reasonable range.

Projections of National Health Expenditures and Actual Growth

Authors	Projection Period Examined	Annual Real Growth Rate		Percentage Difference in Rates
		Projected	Actual	
Freeland and Schendler	1979-1990	4.1	5.4	-24.4
Arnett and Others	1984-1990	3.1	5.7	-45.3
Sonnefeld and Others	1990-2000	4.4	3.3	31.0
Burner, Waldo, and McKusick	1990-2000	5.5	3.3	65.4
Burner and Waldo	1990-2000	4.0	3.3	19.5

Sources: Mark S. Freeland and Carol Ellen Schendler, "National Health Expenditures: Short-Term Outlook and Long-Term Projections," *Health Care Financing Review*, vol. 2, no. 3 (Winter 1981), pp. 97-126.; Ross H. Arnett III and others, "Projections of Health Care Spending to 1990," *Health Care Financing Review*, vol. 7, no. 3 (Spring 1986), pp. 1-36; Sally T. Sonnefeld and others, "Projections of National Health Expenditures Through the Year 2000," *Health Care Financing Review*, vol. 13, no. 1 (Fall 1991), pp. 1-27; Sally T. Burner, Daniel R. Waldo, and David R. McKusick, "National Health Expenditures Projections Through 2030," *Health Care Financing Review*, vol. 14, no. 1 (Fall 1992), pp. 1-29; and Sally T. Burner and Daniel R. Waldo, "National Health Expenditure Projections, 1994-2005," *Health Care Financing Review*, vol. 16, no. 4 (Summer 1995), pp. 221-242 (that article, published in the middle of the time period shown, used historical data for 1990 through 1994).

to the Medicare-Eligible Retiree Health Care Fund.³ CBO projected spending for active-duty personnel and their dependents as well as for retirees and their family members under 65 years of age on a per capita basis, assuming that costs for that population would grow at the same rate as

civilian medical costs—varying from 4.2 percent per capita real growth in 2004 to 2.3 percent in 2020 (*see Table 2*).

Under those assumptions, DoD's projected medical spending (including accrual charges) would increase from \$27 billion in 2003 to about \$46 billion in 2020. If

3. According to Milliman USA, the actuarial firm that performs the accrual analysis for DoD, the rate of 6.25 percent in nominal terms was estimated on the basis of Medicare spending projections in the Medicare trustees' 2001 report (for TRICARE For Life benefits that supplement Medicare) and the Milliman Health Cost Index (for other benefits, including prescription drugs). See Milliman USA, *Analysis of the U.S. Military's Projected Retiree Medical Liabilities as of September 30, 2000*, February 2002, p. II-6. CBO used a constant growth rate for accrual charges, reflecting the present

value of future spending that will take place 20 to 40 years or more into the future. CBO assumed that growth in spending on medical care for the Medicare-eligible population that far in the future would equal the ultimate growth rate—in the case of the midrange estimates, the same 4.1 percent real growth rate used by DoD's actuaries. CBO calculated DoD's total accrual payments on the basis of the size of the active-duty population.

Table 2.

The Department of Defense's Future Medical Spending Under Three Scenarios

	Midrange	Low	High
Projections of DoD's Medical Spending in 2020			
Total (In billions of 2002 dollars)	46	40	52
Per Active-Duty Service Member (In 2002 dollars)	32,800	28,500	37,700
Per dollar of cash compensation	0.73	0.64	0.84
Assumptions			
Growth in Spending for All Beneficiaries Under 65 (Percent)			
2004	4.2	3.0	5.5
2010	3.0	2.1	3.9
2015	2.4	1.7	3.1
2020	2.3	1.6	3.0
Annual Growth in Accrual Charges (Percent)	4.1	2.9	5.3

Source: Congressional Budget Office.

DoD's cash compensation were to grow at the same rate as civilian salaries and wages, the department would be spending about 73 cents on medical benefits for every dollar in cash compensation by 2020. Spending per active-duty service member would increase to \$32,800 by 2020 (see Figure 7).⁴

Low Estimates

In the past, long-term projections of medical cost growth have often varied substantially from actual growth. CBO's low estimates, assuming 30 percent slower real growth than the rates used in the midrange estimates, aim to account for the possibility that national health care costs might grow more slowly than anticipated or that DoD's medical spending might grow somewhat more slowly than national trends. For example, new contracting mechanisms might moderate the growth in purchased care, or military medical treatment facilities might be more successful than their civilian counterparts in holding down costs. Furthermore, DoD's actuaries could have overestimated future growth in the cost of health care for older retirees.

CBO assumed that DoD's accrual payments would grow by 2.9 percent per year in real terms, while the rate of growth for all of DoD's other medical spending would vary from 3.0 percent in 2004 to 1.6 percent in 2020.

Under the low-range assumptions, DoD's total medical spending would grow to \$40 billion by 2020, or about \$6 billion less than projected under the midrange assumptions. Medical spending would reach only 64 cents for every dollar spent on cash compensation rather than the 73 cents expected in the midrange estimates. These low-range estimates imply spending per active-duty service member of \$28,500 by 2020.

High Estimates

In contrast, several factors might contribute to higher-than-expected growth in medical spending after 2003. Civilian medical costs could grow more rapidly than currently projected, or spending on TRICARE could boost DoD's medical spending beyond expectations.

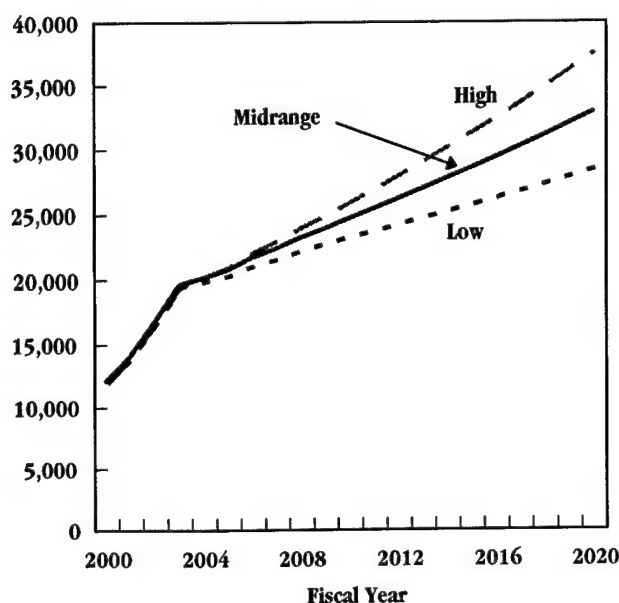
The midrange growth estimates assume a rapid return to relatively modest growth rates after the full implementation of TRICARE For Life and the accrual budgeting system. However, the TRICARE For Life plan is a gener-

4. Those projections differ from CBO's March 2003 baseline projections of DoD's medical spending; see Appendix C for details.

Figure 7.

The Department of Defense's Future Medical Spending per Active-Duty Service Member Under Three Scenarios, 2000 to 2020

(2002 dollars)



Source: Congressional Budget Office.

Notes: Spending includes accrual charges. Calculations for this figure include the Department of Defense's medical spending on all types of beneficiaries divided by the number of active-duty service members.

ous "wraparound" benefit that leaves very few costs for beneficiaries to pay out of pocket. Empirical research on the design of health insurance plans has shown that people who face few out-of-pocket costs tend to use more medical care than those who pay even modest copayments for their care; as a result, some retirees can be expected to increase their health care utilization substantially under TRICARE For Life.⁵ Similarly, family members of active-duty personnel, who now face no out-of-pocket costs under TRICARE Prime or TRICARE Prime Remote, may use more services than expected.

The high-range projection assumes spending growth at a 30 percent higher rate than that assumed in the midrange estimates. Under the high-range assumptions, spending would increase at a real rate of 5.5 percent per capita in 2004 and fall to 3.0 percent in 2020, while accrual charges would grow at 5.3 percent per year in real terms. Under this scenario, total spending on defense health care would grow to \$52 billion by 2020, or about \$7 billion more than the midrange estimates predict. Medical spending would reach 84 cents for every dollar spent on cash compensation, compared with 73 cents under the midrange estimates. Spending per active-duty service member would rise to \$37,700.

5. See W. Manning and others, "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment," *American Economic Review*, vol. 77, no. 3 (1987), pp. 251-277, and R. Brook and others, "Does Free Care Improve Adults' Health? Results from a Randomized Controlled Trial," *New England Journal of Medicine*, vol. 309, no. 23 (1983), pp. 1426-1434.

The Effects of Legislative and Policy Changes on DoD's Projected Health Care Spending

The midrange, low, and high projections presented in the previous chapter assume that the Department of Defense's policies remain fixed and that no legislated changes in benefits or coverage take place. Certainly, though, changes in policies or laws could cause health care costs—and the ratio of health care costs to cash compensation—to diverge widely from those projections.

Future Health Care Spending Under Policies That Could Slow Growth

Continued increases in health care costs relative to cash compensation might at some point lead service members, DoD, and the Congress to reassess the cost-effectiveness of the department's current compensation system. The total military compensation package—which includes immediate cash, deferred retirement pay, and immediate and deferred health care benefits, as well as other in-kind benefits—must be sufficient to attract and retain highly qualified personnel. The constant ratio of health care benefits to cash compensation in the private sector, however, suggests that the most cost-effective compensation package—the one that for a given cost is most attractive to employees—is one in which cash dominates. Private-sector health care plans typically entail copayments, deductibles, and managed care not because employees like those features, but because employers have found that a compensation package that includes more cash wages combined with moderately priced health insurance options

provides the best package for recruiting and retaining workers.

This paper examines two policy changes—drawn from trends in private-sector health care and a change in DoD's retirement system—that would allow DoD to slow the growth in health care spending and raise cash compensation. In the first, military retirees are allowed to choose between coverage under TRICARE For Life and cash; in the second, the families of active-duty service members are allowed to choose either TRICARE's current options or a less generous plan and cash. Both of those possible policy changes involve choice; all military families that preferred to remain under the current system could do so. Nonetheless, the Congressional Budget Office finds that those policies could save DoD \$1.5 billion annually (in 2002 dollars) by 2020.

The two policies were selected to illustrate the potential offered by arrangements that seek to balance health care benefits and cash compensation. The two policies alone, however, would not be sufficient to forestall continued increases in medical spending relative to cash compensation. Even if both were adopted, DoD's health care spending would rise from 55 cents for every dollar of cash compensation today to 70 cents by 2020. Maintaining the current ratio would require more far-reaching changes, such as coupling increases in cash compensation with the introduction of premiums (which would reduce DoD's costs by encouraging families with access to plans offered

by private employers to choose those plans more frequently), deductibles, and copayments.

Option: A Retirement Bonus in Lieu of Health Care Over Age 65

The present value of TRICARE For Life coverage is \$172,000 for a service member retiring in 2004.¹ That figure includes both the value of the service member's own coverage as well as the value of coverage for his or her dependents (but it does not include the value of the benefits the retiree and his or her dependents will receive before reaching age 65). Because health care costs are expected to grow faster than inflation, by 2020 the value of TRICARE For Life for a new retiree will reach \$319,000 (in 2002 dollars). Yet many military retirees could seek retiree health coverage from a future civilian employer or a spouse's employer, and others might prefer to purchase a less generous private Medicare supplement (known as a "medigap" plan) or to save money and self-insure rather than receive so much of the value of their retirement benefits in the form of health insurance. Those possibilities suggest that retirees could be given an option at retirement: retain TRICARE For Life coverage for themselves and their dependents or receive a cash bonus.² As an example, DoD could offer the retirees and their families a cash bonus equal to one-half of the present value of those benefits to spend as they wish. The after-tax bonus that could be offered to service members retiring today would be \$86,000 (one-half of \$172,000).³ The value of the

bonus offered to retirees could rise over time as health care costs grew. By 2020, this level of cash bonus at retirement would be approximately \$159,000.

If even a few retirees chose this option, the federal government would see a cost savings in the long run.⁴ For example, if only 10 percent of retiring service members chose this option, the present value of future savings to the federal government could equal \$117 million in 2004, and that number would rise each year as long as medical cost growth outstripped overall inflation.⁵ The present value of savings to the government could exceed \$217 million in 2020. However, substantial expenditures would occur in the short run as retiring service members took the bonuses, while the savings would occur much later, after retirees and their dependents reached 65 years of age. Thus, in the short run, at least, this proposal would increase federal outlays.

However, DoD itself could see a savings within a few years because of the accounting method used to pay for TRICARE For Life benefits. If, as assumed above, 10 percent of retiring service members received a bonus of one-half the present value of their TRICARE For Life benefits in return for waiving coverage under the program, and if the same share of newly retiring service members took the bonus each year, DoD's actuaries would be able to take the future savings into account when calculating the annual accrual payments to be made into the retiree health care fund. The annual budgetary savings to DoD would

1. Personal communication from DoD's Office of the Actuary, February 6, 2003. That figure includes the payment of Medicare's copayments and deductibles, the TRICARE Senior Pharmacy benefit, and the cost of care provided at military medical treatment facilities. Retirees waiving TRICARE For Life would also be waiving access to care at DoD hospitals. CBO's calculation used a nominal discount rate of 6.25 percent.

2. This bonus option is similar to the career status bonus offered to eligible military service members at their 15th year of service. Those accepting the bonus receive a \$30,000 up-front cash bonus in return for accepting the REDUX retirement system, which generally pays lower pension benefits during retirement than the alternative retirement system based on service members' "high three" years of compensation.

3. The government could offer a tax-free bonus of \$86,000 or offer a higher taxable bonus that would have the same after-tax value. If the bonus was taxable, retirees could be given the option of receiving the bonus in installments over a five-year period in order

to reduce the tax liability.

4. That conclusion presumes that adverse selection would not be severe—that is, that retirees choosing the cash bonus option would not be so far below the average risk that they would have cost the government *less* than the cash bonus if they had remained under the current system. The extent of adverse selection would probably be low because military retirement generally occurs decades before TRICARE For Life coverage starts, making it difficult for service members to predict their future need for health care, and because TRICARE For Life is structured in a manner that discourages the purchase or use of other health insurance by imposing additional paperwork on people with such insurance; as a result, relatively few eligible individuals would be likely to forgo TRICARE For Life in the absence of this option providing a cash bonus.

5. CBO assumed that about 20 percent of the savings would be offset by increases in spending by the Federal Employees Health Benefits program and the Department of Veterans Affairs.

be around 10 percent of the total accrual charge, or \$795 million in 2004. After taking into account outlays of \$117 million on bonuses, DoD would have a net savings of \$649 million in 2004, rising to \$1.2 billion in 2020 even if the share of retirees choosing the bonus stayed fixed at 10 percent.

Because retiring service members would retain the option of remaining in the current system, this policy change would increase their choices about the structure of their compensation.

Option: A "Cafeteria Plan" for the Health Benefits of Family Members of Active-Duty Personnel

Studies of health insurance in the civilian sector indicate that copayments, deductibles, and more stringent managed care restrictions can significantly decrease health care spending by reducing unnecessary use of the system without adversely affecting the overall health of each beneficiary.⁶ Unlike most private health plans, however, TRICARE charges few copayments or deductibles to constrain the demand for care. Three-quarters of the family members of active-duty personnel are enrolled in TRICARE Prime and face no copayments or deductibles for health care received from network providers, regardless of whether those providers are military or civilian. Although TRICARE Prime provides some cost control using managed care methods, utilization rates in the program remain 40 percent to 50 percent higher than those in civilian plans.⁷ Given a choice, some family members of active-duty personnel may prefer a compensation plan that offers them more cash and a somewhat less generous health care benefit.

This option would give family members that choice by establishing a "cafeteria plan" for their health coverage. In the private sector, employers have turned increasingly to various types of flexible benefit plans to allow workers to adjust the mix of benefits that they receive to most suit

their needs and preferences.⁸ Under the cafeteria plan considered here, DoD would provide each family with a cash allowance for its health coverage. The allowance could be used in one of three ways. First, family members could purchase TRICARE coverage, which would include any of the current options (TRICARE Standard, TRICARE Extra, and TRICARE Prime).⁹ Second, they could use some of the money to purchase a new "low-option" TRICARE plan and keep the remaining funds. That version of TRICARE would be similar to TRICARE Prime in that it would have many managed care features. However, it would also incorporate a substantial deductible as well as copayments for health care services, whether obtained at military medical treatment facilities or from civilian providers. Third, military family members could show proof of employer-provided insurance and apply the allowance toward their share of the premiums, copayments, and deductibles for that insurance. Active-duty service members themselves would still be automatically enrolled in TRICARE Prime; only the dependents of active-duty service members would have the new choices. Those choosing the low-option TRICARE plan would be protected against catastrophic costs by a "stop-loss" of no more than \$3,000 in out-of-pocket costs per year.¹⁰

By CBO's estimates, such a plan would reduce DoD's outlays by 25 percent per beneficiary (not including the cost of the cash allowance). If DoD offered those families opting out of traditional TRICARE coverage a cash allowance of \$1,000 for coverage of a spouse or \$2,000 for family coverage and if beneficiaries could choose the new low-option TRICARE plan by paying only half of that cash allowance as a premium, DoD's net savings would be \$18 million in 2004, rising to \$185 million in 2006 (as the program phased in and more families participated) and perhaps \$245 million annually by 2020. (See

6. See, for example, W. Manning and others, "Health Insurance and the Demand for Medical Care"; and R. Brook and others, "Does Free Care Improve Adults' Health?"

7. Department of Defense, *Evaluation of the TRICARE Program: Fiscal Year 2003 Report to Congress* (April 2003).

8. According to data from the Employee Benefit Research Institute, from 1991 to 1997, there was a 30 percent increase in the percentage of full-time employees participating in cafeteria plans and other flexible benefit plans at medium-sized to large private firms.

9. The amount of the cash allowance would equal the price charged for any of the three traditional TRICARE plans, so that families choosing one of those plans would be no worse off than under current policy.

10. For additional discussion of the pros and cons of this policy change, see Congressional Budget Office, *Budget Options* (March 2003).

Box 3.**Estimating the Savings from Introducing a Cafeteria Plan**

The Congressional Budget Office's (CBO's) estimate of the impact of introducing a cafeteria plan for the family members of active-duty personnel incorporates several key factors:

- The cost of the cash allowances of \$1,000 for coverage of a spouse and \$2,000 for coverage of a family (rising with inflation each year).
- A decrease in demand for health care by those choosing the new low-option plan, as copayments and deductibles improved the efficiency of health care utilization. CBO assumes that the plan would be structured to reduce the Department of Defense's (DoD's) spending on enrollees by 25 percent. CBO estimates that 13 percent of family members would choose coverage under the low-option plan if it cost half the value of the cash allowance.
- Savings to DoD from the fact that more family members would be likely to take advantage of employer-sponsored health insurance, which most currently forgo. CBO estimates that 4 percent of family members would take the cash allowance and switch from TRICARE to an employer plan.
- A cost increase due to a small number of eligible family members who are not currently using TRICARE (known as "ghosts") and who thus cost nothing to the system at the moment but who would apply for the cash allowance. CBO estimates that 2 percent of family members would fall into this category.

Box 3 for a discussion of the factors incorporated in CBO's estimates.)

Policy changes like this one and the preceding one would not stop aggregate cost growth. Taken together, the two policy changes would save DoD \$1.5 billion by 2020. But

to maintain the current ratio of spending on health benefits without increasing cash compensation more than anticipated, DoD would need to cut medical spending by over \$11 billion by that year. That reduction would require more radical changes to benefits, such as the introduction of premiums and increases in deductibles and copayments. An alternative approach would be to lengthen military careers, thus extending the number of years of service required to be eligible for lifetime health care coverage.

Policies That Could Accelerate the Growth of Health Care Spending

Yet even if DoD and the Congress try to control future growth in health care spending, they will face pressure to adopt policies that could result in increases. This study examines two areas in which such pressures are already being felt. One relates to the nature of the health care benefits provided to reservists. The other addresses the difference between the benefits available to retirees who are eligible for Medicare and those who are not.

How DoD and the Congress respond to pressures for additional benefits could have a significant impact on the department's future health care spending. Furthermore, CBO's examination of potential benefits for reservists shows how alternative health care programs that might address readiness could have dramatically different cost implications. And the examination of benefits for retirees under age 65 illustrates how the introduction of new, relatively inexpensive, benefits in the current system could lead to pressure for still additional, and more costly, benefits.

Option: Extended Benefits for Reservists

In recent years, the U.S. military has come to rely increasingly on the Reserves and the National Guard as key components of the force structure. CBO examined two approaches that have been proposed by lawmakers to increase medical benefits for reservists.¹¹ While the first

11. The term "reservists" is used throughout this report to refer to members of the Selected Reserve, including the U.S. Army Reserve, U.S. Air Force Reserve, U.S. Marine Corps Reserve, U.S. Naval Reserve, Army National Guard, and Air National Guard.

option is targeted at helping reservists and their families maintain their civilian coverage while the reservists are deployed, the other, more expensive, option provides reservists with full-time access to TRICARE coverage even when they are not mobilized.

In the past decade, call-ups of reservists have become more frequent. Since September 11, 2001, the average tour for reservists has lengthened to 300 days, up from 140 days in 1990 and 1991.¹² As reservists play a larger role, concerns have grown about the burden being placed on them, their families, and their employers.¹³ Lengthy or frequent call-ups can disrupt reservists' civilian employment and create challenges for ensuring continuous health coverage for their families.

Whenever a reservist is called to active duty for 30 days or more, his or her family becomes eligible for TRICARE coverage. Alternatively, the family can choose to retain the reservist's civilian employer-sponsored health coverage for up to 18 months. However, after the reservist's first 30 days on active duty, the employer may require the reservist to pay the full premium (both the employee's and the employer's shares) as well as a 2 percent administrative charge.¹⁴ If the reservist chooses to drop civilian coverage while on active duty, the employer must later reinstate

the reservist and his or her family without a waiting period and without excluding coverage for any preexisting health conditions that may have emerged for anyone in the family.¹⁵

While some mobilized reservists choose to stay on their employer's health plan, some switch to TRICARE in order to save on premiums.¹⁶ The transition from an employer's plan to TRICARE and then back to the employer's plan at the end of the deployment can be disruptive for families, particularly when a family member has a chronic or serious illness and the changes in coverage would require switching doctors.

Several alternatives have been suggested to improve the health coverage available to reservists and their families. Two primary goals for any policy change are:

- Continuity of coverage for families when reservists are deployed, and
- Ensuring that reservists have coverage regardless of deployment status.

Two proposals focusing respectively on those goals have been considered by the Senate and were incorporated in the Senate version of the National Defense Authorization Act for Fiscal Year 2004 (S. 1050).

Helping Reservists Retain Civilian Coverage for Their Families. Rather than providing a reservist's family with full-time coverage under TRICARE or switching the family out of its civilian plan each time the reservist was deployed, the first option would have DoD pay any out-of-pocket costs associated with continuing the civilian coverage during the deployment. The amount reimbursed would be capped at the cost of TRICARE coverage (which would remain an option for families choosing to switch) and could pay the reservist's share of premiums as well

12. Personal communication from the Office of the Assistant Secretary of Defense for Reserve Affairs, August 4, 2003.

13. DoD has implemented a demonstration project for reservists activated for more than 30 days in support of operations that result from the terrorist attacks of September 11, 2001. For those eligible, the department has increased the maximum allowable charge for civilian care and is waiving deductibles in the TRICARE Standard and Extra plans and requirements that enrollees obtain statements attesting to the unavailability of services at military medical treatment facilities before seeking nonemergency care from a civilian provider. Those measures are intended to ease the transition and reduce the out-of-pocket costs for a family switching from a civilian health plan to TRICARE while the reservist is deployed. A second demonstration project provides transitional health coverage after deactivation for between 60 and 120 days, depending on the reservist's number of years of military service.

14. Department of Defense, "Healthcare Benefits for Reserve Component Members on Active Duty More than 30 Days and Their Families," available at www.tricare.osd.mil/RNGOLBrochure/Reservereprint.pdf.

15. The military and/or Department of Veterans Affairs is responsible for providing treatment for medical conditions attributed to military service. See www.tricare.osd.mil/reserve.

16. General Accounting Office, *Defense Health Care: Most Reservists Have Civilian Coverage But More Assistance Is Needed When TRICARE Is Used*, GAO-02-829 (September 2002).

as any copayments and deductibles. While some employers cover their share of premiums for mobilized reservists beyond the 30 days currently required, most reservists normally have to pay the full premiums to continue coverage for their families under their employer's plan. On average, employer-sponsored family health coverage costs nearly \$8,500 per year, including both the employer's and the employee's shares of the premiums.¹⁷

The cost of providing this benefit to the families of mobilized reservists would be about \$71 million in 2004, CBO estimates. That estimate takes into account the unusually high number of reservists currently mobilized. Spending on this benefit would fall to \$6 million by 2009 under the assumption that fewer reservists would be mobilized in the future. Spending would then slowly rise to \$9 million in 2020 as health care costs increased somewhat more quickly than inflation.

Providing Full-Time TRICARE Coverage for All Reservists.

The second option would incorporate all of the features of the one just discussed but would also offer TRICARE coverage to reservists and their families regardless of the reservists' deployment status.¹⁸ The primary purpose would be to ensure comprehensive, continuous health coverage for them. For that reason, the premiums charged would be held low—for enlisted reservists, only \$330 annually for individual coverage or \$560 for family coverage, and for officers, \$380 for individual coverage or \$610 for family coverage.¹⁹ Those premiums are somewhat higher than those paid by military retirees under age 65 for TRICARE Prime but lower than the average amounts

that civilian employees contribute for their coverage (currently \$456 for a single person or \$2,088 for a family).²⁰ Some reservists who live far from a military medical treatment facility would find it difficult to use any TRICARE option except Standard, which might expose them to substantial out-of-pocket costs if a family member became seriously ill.²¹

According to CBO's estimates, this proposal would cost approximately \$454 million in 2004 and would then phase in over three more years to cost \$1.8 billion in 2007. Eventually, as health care costs rose faster than inflation, the proposal would cost \$3.1 billion in 2020. The cost of this proposal is considerably higher than the first because all reservists, not just those mobilized, would be eligible to receive the benefit. CBO assumed that 40 percent of reservists with private insurance would drop that insurance in favor of TRICARE coverage, given the low annual premiums.

However, this proposal fails to take advantage of the health insurance options currently available to most reservists through their civilian employers or their spouses' employers. If reservists who were not deployed were offered comprehensive TRICARE coverage at very low premiums, many would drop their civilian coverage, essentially resulting in a transfer of costs from the civilian employers to DoD. A recent report by the General Accounting Office indicated that nearly 80 percent of reservists had health care coverage when not on active duty.²² Thus, this proposal arguably carries a relatively high cost compared to the modest increase in the number of reservists and their families who would gain health insurance.

17. *The Kaiser Family Foundation and Health Research and Education Trust Employer Health Benefits 2002 Survey* (Menlo Park, Calif.: Kaiser Family Foundation, 2002).

18. This benefit would be offered only to members of the Selected Reserve who take part in regular training exercises as part of a Reserve or National Guard unit. CBO assumed that other groups of reservists who are much less likely to be mobilized, including the Individual Ready Reserve, Inactive National Guard, Standby Reserve, and Retired Reserve, would not be offered this benefit.

19. Those premiums are based on the Graham-Daschle amendment added to S. 1050, the Senate version of the National Defense Authorization Act for Fiscal Year 2004, on May 19, 2003.

20. *The Kaiser Family Foundation Employer Health Benefits 2002 Survey*.

21. This proposal assumes that deployed reservists would also be offered the reimbursement described above in the proposal for retaining civilian coverage. The availability of that benefit would affect the number of reservists likely to choose TRICARE coverage. A reservist who expected frequent call-ups might decide that his or her family was better off staying in a civilian plan and receiving reimbursement during times when the reservist was deployed.

22. General Accounting Office, *Defense Health Care: Most Reservists Have Civilian Coverage*.

Option: Expanded Benefits for Retirees Under 65 Years of Age

With the introduction of TRICARE For Life, military retirees and their dependents over 65 years of age now enjoy low-cost health care from either military or civilian providers.²³ When space is available, visits to military medical treatment facilities remain free, and TRICARE For Life now pays most of the copayments and deductibles for services covered by Medicare and delivered by civilian providers. Pharmaceuticals are subject to copayments as low as \$3 per prescription, and free medicines are available from military medical treatment facilities. Participants must pay the Medicare Part B premium, which is currently \$58.70 per month.

That more generous benefit for beneficiaries over age 65 has led some retirees and dependents *under* 65 to seek similar coverage. The premiums, copayments, and deductibles paid by military retirees and their dependents under age 65, while comparable to charges paid by civilians, can amount to far more than the nearly free care now available to retirees and dependents over 65. While TRICARE For Life pays beneficiaries' expenses not covered by Medicare, TRICARE Standard normally does not cover the copayments and deductibles left unpaid by private health insurance policies held by retirees under age 65. Rather, TRICARE pays the lesser of the following:

- An amount of up to 15 percent more than TRICARE Standard's allowable charge minus the amount that the other health insurance paid or
- The amount that TRICARE Standard would have paid if the beneficiary did not have any other health insurance.

In some cases, then, TRICARE Standard currently pays nothing for services covered by retirees' civilian health plans when the amount the other insurance company pays is more than 115 percent of TRICARE's allowable charge.

That policy could be changed to make TRICARE Standard complement retirees' civilian employer-provided health insurance in the same way that TRICARE For Life complements Medicare coverage.²⁴ While that change in benefits is not under consideration by the Congress, it has been proposed by advocates for military retirees. CBO chose to analyze this option because it is one of many such proposed changes that would increase the level of coverage provided by the TRICARE program for some beneficiaries.²⁵

Under this option, no matter how much the providers billed, TRICARE Standard would pay any remaining balance up to the amount it would have paid if there were no other insurance—usually 75 percent to 80 percent of TRICARE's allowable charge. In many circumstances, that amount would be enough to cover the entire cost left over after the retiree's other insurance has paid. As with TRICARE For Life, beneficiaries would be left with almost no out-of-pocket costs.

By CBO's estimates, altering the coverage rules for TRICARE Standard so that it "topped off" other health insurance would cost \$1.8 billion in 2004 and \$3.5 billion by 2020. That estimate assumes that use of the health care system by retirees and their dependents with civilian insurance would increase by 25 percent because they would

23. Until October 2001 (that is, the beginning of fiscal year 2002), military retirees and their dependents lost their eligibility to receive services from civilian providers under TRICARE when they became eligible for Medicare. While they could still obtain free care from military medical treatment facilities, access to such care was on a space-available basis. When a number of base hospitals and clinics were closed or downsized in the 1990s, such care became increasingly scarce. In fiscal year 2002, the TRICARE For Life program was instituted to provide a wraparound benefit for military retirees and their dependents who were eligible for Medicare.

24. While TRICARE Prime and Extra are available to military retirees and dependents under age 65, they can reduce out-of-pocket costs only for those who live near military medical treatment facilities and in areas with extensive networks of TRICARE providers.

25. See, for example, Statement of Robert Washington, Sr., Fleet Reserve Association, Cochairman, the Military Coalition Health Care Committee, and Sue Schwartz, Military Officers Association of America, Cochairman, the Military Coalition Health Care Committee, before the Subcommittee on Total Force of the House Committee on Armed Services, March 27, 2003.

face few out-of-pocket costs.²⁶ Under this option, about a quarter of the total cost of care for this population would be borne by TRICARE and the remaining three-quarters by the civilian health plans, CBO estimates.

However, improving TRICARE Standard for retirees who have civilian coverage could lead to still further pressures to expand benefits for other retirees. The policy change described here would not help retirees who did not have

26. CBO's assumption here is consistent with the methodology used to determine the cost of the "low-option" TRICARE plan. For that option, the introduction of copayments and deductibles was assumed to reduce total spending by 25 percent.

civilian coverage and who relied on TRICARE Standard as their sole source of insurance. Those retirees might seek additional expansions of coverage, which could increase DoD's spending even more.

As this chapter has demonstrated, decisions about benefits will play a key role in the future growth of DoD's medical spending. While some proposals currently being considered could substantially increase spending per active-duty service member and result in a compensation package that is even more heavily weighted toward medical benefits, other options could provide new choices for service members and their families while moderating future growth.

A

Background on the Department of Defense's Medical Coverage

The collection of the Department of Defense's (DoD's) health plans is known as TRICARE. Beneficiaries covered to one degree or another by the program include:

- Active-duty service members,
- Dependents of active-duty service members,¹
- Military retirees,²
- Dependents of military retirees,
- Full-time reservists,³
- Dependents of full-time reservists, and

-
1. Dependents include spouses, including ones who have divorced but not remarried, and unmarried children (up to age 21).
 2. Retirees have generally served 20 or more years in uniform or have been medically retired owing to an illness or injury incurred while serving in a branch of the armed forces. The normal military retirement age is around 38 to 45 years. Currently, more than half of the population of military retirees is under the age of 65.
 3. While most reservists are in uniform only part time, a minority serve full time to ensure the continuing operation of Reserve and National Guard units. Reservists can also be called to active duty for 30 days or more. Full-time reservists and reservists mobilized for more than 30 days, along with their families, are entitled to medical care under rules that are similar to those for regular active-duty service members.

- Survivors of military retirees or those who died on active duty.⁴

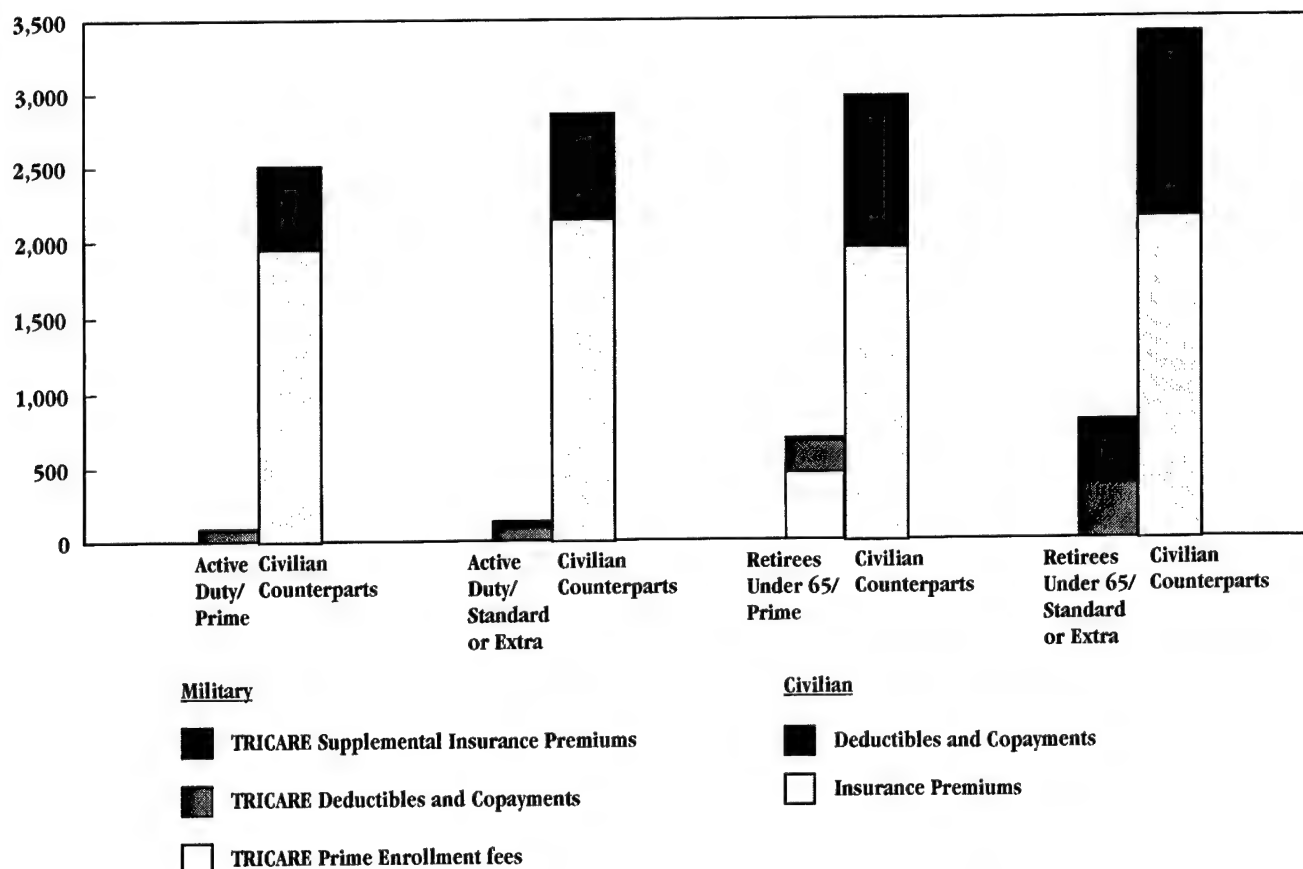
The TRICARE program combines military medical treatment facilities with regional networks of civilian providers that work together to provide care to eligible beneficiaries. The military medical treatment facilities include 75 hospitals and over 460 clinics in the continental United States and overseas. Those facilities provide care for eligible beneficiaries at no charge and also serve as a training ground for military medical personnel. Because the military health system's capacity is not large enough to serve the health care needs of all eligible beneficiaries, DoD has ensured that active-duty service members receive top priority for care at the facilities, while other beneficiaries can receive care there on a "space-available" basis. Many beneficiaries also seek care from civilian providers paid for through the TRICARE program.

Individuals have access to different levels and types of benefits depending on which type of beneficiary they are. Active-duty service members must go to military medical treatment facilities for their care. Family members of active-duty personnel as well as military retirees and dependents who are not eligible for Medicare can choose from one of three main options:

-
4. Survivors include widows and widowers who have not remarried and unmarried children (up to age 21) of deceased active-duty or retired service members.

Figure A-1.**Out-of-Pocket Costs for Military Families Using the TRICARE Program and for Their Civilian Counterparts, 2002**

(2002 dollars)



Source: Department of Defense, *Evaluation of the TRICARE Program, Fiscal Year 2003 Report to Congress* (April 2003).

Note: For military families, the designations refer to the status of the service member and the TRICARE program in which they are enrolled; for example, Active Duty/Prime refers to families of active-duty service members that are enrolled in TRICARE Prime.

- *TRICARE Prime* is similar to a civilian health maintenance organization (HMO). Beneficiaries are assigned to a primary care manager, who coordinates all aspects of their medical care.
- *TRICARE Standard* is a fee-for-service plan that allows beneficiaries to seek care from any civilian provider and be reimbursed for a portion of the costs after paying copayments and meeting deductibles. For some services, beneficiaries are required to seek

care first from a military medical treatment facility when possible.

- *TRICARE Extra* is similar to a civilian preferred provider organization. Beneficiaries pay lower copayments than they would under TRICARE Standard if they seek care from a provider in the TRICARE network.

Retirees and dependents over 65 years of age or otherwise eligible for Medicare are not eligible for those TRICARE

plans. Instead, they are eligible for care at military hospitals and clinics as space allows and for *TRICARE For Life*, a wrap-around benefit for those with Medicare.⁵ Under TRICARE For Life, Medicare usually pays first, while TRICARE covers most or all of the rest of the bill. Prescription medications for this population are provided free at military medical treatment facilities or for a modest copayment through the *TRICARE Senior Pharmacy* benefit.⁶

Several smaller plans provide additional options for individuals living in certain areas. For example, *TRICARE Prime Remote* is a plan for active-duty service members and their families who live and work more than 50 miles or approximately one hour's drive from a military medical treatment facility.

DoD's recent evaluation of the TRICARE program found that over 76 percent of the family members of active-duty personnel were enrolled in TRICARE Prime in 2002.⁷

-
5. The TRICARE For Life benefit was introduced in October 2001 (the beginning of fiscal year 2002), adding coverage for services received from civilian providers by complementing the Medicare program. Previously, military retirees and their dependents who were eligible for Medicare were entitled to receive medical services and pharmaceuticals at military medical treatment facilities when space was available but had no coverage for care received from civilian providers.
 6. TRICARE Senior Pharmacy was introduced on April 1, 2001. Medicare does not cover most outpatient pharmaceuticals.
 7. Department of Defense, *Evaluation of the TRICARE Program: Fiscal Year 2003 Report to Congress* (April 2003).

The remainder were using some mix of TRICARE Standard, TRICARE Extra, and civilian health insurance plans. By comparison, fewer than 33 percent of military retirees and their family members under age 65 were enrolled in TRICARE Prime in that year. Most other retirees and their dependents under 65 had some type of civilian health insurance, although some were relying on TRICARE Standard or Extra.

The evaluation also found that (after adjusting for the different demographic characteristics) TRICARE Prime enrollees had utilization rates that were 40 percent to 50 percent higher than those for civilian HMO members. The difference in utilization can be traced in part to the very different out-of-pocket costs faced by TRICARE beneficiaries as compared to their civilian counterparts (see *Figure A-1*). TRICARE beneficiaries, whether they use TRICARE Prime, Standard, or Extra, faced dramatically lower total costs for their coverage. Much of the difference reflects insurance premiums. Only military retirees who enroll in TRICARE Prime face any sort of enrollment fee, although many who use Standard or Extra also purchase a supplemental insurance policy to help cover the copayments and deductibles. The TRICARE Prime enrollment fee is small compared with the employees' share of civilian insurance premiums faced in the private sector. Besides the insurance premiums, other out-of-pocket costs such as copayments and deductibles are dramatically lower for military beneficiaries than they are for their civilian counterparts. Such costs can help temper demand for medical care and thus hold down total costs.

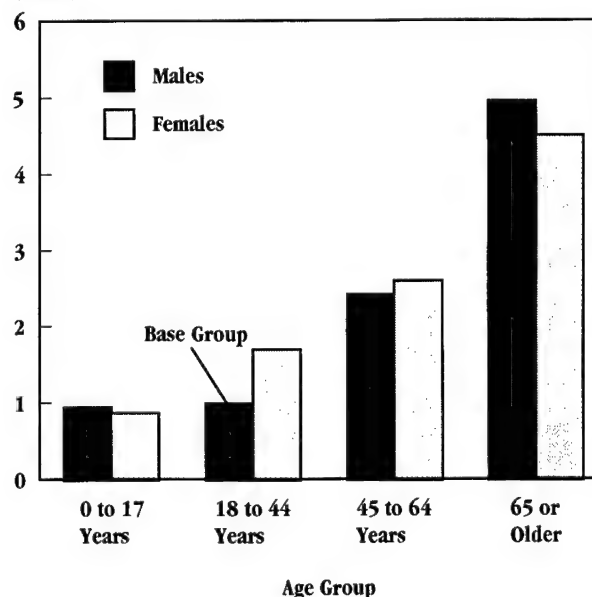
B

Adjusting for the Changing Mix of the Department of Defense's Beneficiaries

The Congressional Budget Office (CBO) used the Medical Expenditure Panel Survey, conducted by the Agency for Healthcare Research and Quality, to identify a civilian population of beneficiaries that was comparable to the Department of Defense's (DoD's) and examined the relative medical expenditures of that civilian population.¹ CBO broke the population down by sex and by age group (up to 17 years of age, 18 to 44, 45 to 64, and 65 or older). Average total medical expenditures varied among those groups from around \$1,000 for females up to age 17 to over \$5,800 for males age 65 or older (see Table B-1). Using males who were 18 to 44 years old as the base group, CBO converted average expenditures into relative weights ranging from 0.87 to 4.95.² For example, the figure for males age 65 or older indicates that that group spent, on average, 4.95 times as much as males between 18 and 44 years old did (see Figure B-1).

CBO then divided the population of DoD beneficiaries up into those same groups and multiplied the total num-

Figure B-1.
Relative Medical Costs for a Civilian Population, by Age and Sex
(Ratio)



Source: Congressional Budget Office using data from the Agency for Healthcare Research and Quality's 1996 Medical Expenditure Panel Survey.

Note: CBO used a comparable civilian population that included only those with private insurance and/or Medicare because the uninsured and people with only Medicaid probably use the health care system substantially differently from the ways that the Department of Defense's beneficiaries do. The base group consisted of males who were 18 to 44 years old to correspond to the bulk of the Department of Defense's beneficiaries on active duty. CBO excluded from its sample very high cost outliers—or people with annual expenditures over \$250,000—because of their disproportionate effect on average costs.

1. The data are from the Agency for Healthcare Research and Quality's 1996 Medical Expenditure Panel Survey, within the consolidated data file for the full year, which was updated in March 2001. The information is available at www.meps.ahrq.gov/Puf/DataResultsData.asp?ID=20. CBO used a comparable civilian population that included only people with private insurance and/or Medicare because the uninsured and people with only Medicaid probably use the health care system substantially differently from the ways that DoD's beneficiaries do.

2. CBO chose males ages 18 to 44 because they make up the largest group within the active-duty force, although the results would not differ in substance if any other group was chosen as the base group.

Table B-1.

Total Annual Medical Expenditures per Capita in a Civilian Population, by Age and Sex

Age Group	Expenditures in 2002 Dollars		Relative Expenditures	
	Males	Females	Males	Females
0 to 17 Years	1,114	1,028	0.95	0.87
18 to 44 Years	1,177	2,009	1.00	1.71
45 to 64 Years	2,865	3,071	2.43	2.61
65 or Older	5,823	5,306	4.95	4.51

Source: Congressional Budget Office using data from the Agency for Healthcare Research and Quality's 1996 Medical Expenditure Panel Survey.

Notes: To provide a comparable civilian population, CBO included only people with private insurance and/or Medicare because the uninsured and people with only Medicaid probably use the health care system substantially differently from the ways that the Department of Defense's beneficiaries do.

The base group consisted of males who were 18 to 44 years old to correspond to the bulk of the Department of Defense's beneficiaries on active duty.

CBO excluded from its sample very high cost outliers—or people with annual expenditures over \$250,000—because of their disproportionate effect on average costs.

ber in each group by the appropriate weight. Because older beneficiaries impose a heavier burden on any health care system, converting each beneficiary into an imaginary number of “weighted beneficiary units” makes tracking the total demand placed on the system easier. For example, if 450 beneficiaries convert into 875 weighted beneficiary units, the demand on the system would equal that by a beneficiary population consisting of 875 males between 18 and 44 years of age and no one else.

CBO then adjusted those weighted beneficiary units for the beneficiaries' different rates of reliance on DoD's health care system (including both military medical treatment facilities and civilian providers) by multiplying the number of weighted beneficiary units in each category by the following full-time-equivalent weights:

- Active-duty personnel: 1.00
- Family members of active-duty personnel: 0.95
- Retirees, family members, and survivors under age 65: 0.64
- Retirees, family members, and survivors over age 65: 0.30

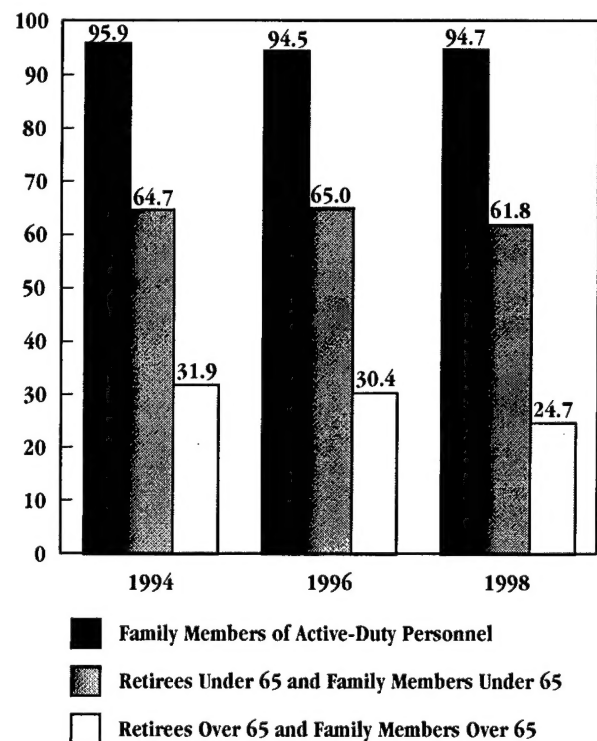
Those figures represent the approximate average rates of reliance for each group, as revealed by surveys by DoD taken from 1994 to 1998. In reality, utilization by some groups, particularly retirees over age 65, fell during the time when the surveys were taken. Older retirees sought 32 percent of their care from military medical treatment facilities in 1994 but less than 25 percent by 1998, probably because the closure and downsizing of military medical treatment facilities made it more difficult to obtain care on a space-available basis (see *Figure B-2*).

While it might be possible to vary the adjustment factors to reflect changes in the rates of reliance over time, doing so would mask the impact of those changes in reliance on DoD's system and attribute them to the changing mix of beneficiaries rather than to the reduced use of the system by some groups. Such reduced use could reflect growing access to or preference for alternative sources of care (such as employer-provided health insurance or Medicare), or it could reflect the “squeezing out” of some beneficiaries as space-available care became more difficult to obtain.

After weighting the beneficiary population by sex/age group and by rates of reliance, the end result is a number of “full-time-equivalent beneficiary units”—essentially,

Figure B-2.**Percentage of Care Provided by the TRICARE Program**

(Percent)



Source: Department of Defense, Office of the Assistant Secretary for Health Affairs.

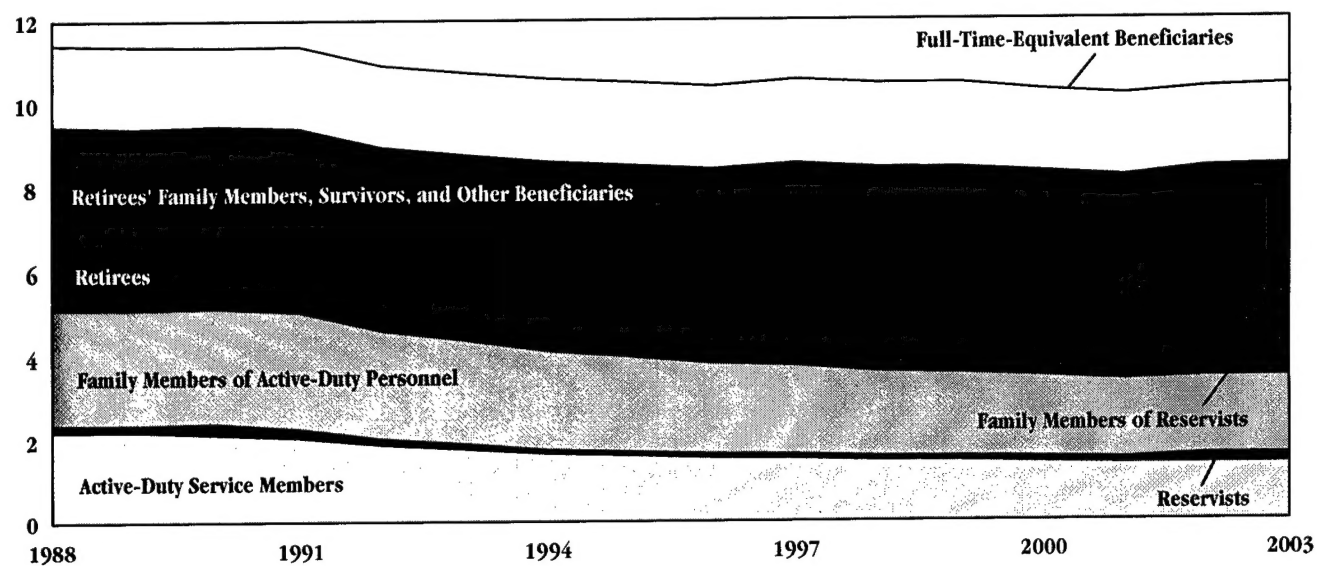
the number of full-time active-duty males ages 18 to 44 that it would take to impose the same approximate demand on the system as the actual mix does. While the number of beneficiaries decreased from 9.5 million to 8.5 million from 1988 to 2003 (an 11 percent decrease), the number of full-time-equivalent beneficiary units dropped from 11.4 million to 10.4 million (a 9 percent decrease). (See Figure B-3.)

Dividing DoD's total medical expenditures by the number of full-time-equivalent beneficiary units, CBO finds that real spending per unit rose from \$1,300 in 1988 to \$2,600 in 2003, or by about 5 percent annually.

Figure B-3.

The Department of Defense's Health Care Beneficiaries and Full-Time-Equivalent Beneficiaries, 1988 to 2003

(Millions)



Source: Congressional Budget Office based on data from the Defense Enrollment Eligibility Reporting System and the Managed Care Forecasting and Analysis System.

C

Comparison of the Midrange Projections and CBO's Baseline for the Department of Defense's Medical Care

The midrange estimates of future medical spending by the Department of Defense (DoD) presented in this study are somewhat different from the Congressional Budget Office's (CBO's) estimates of such spending in its March 2003 baseline. Starting from essentially the same level of budget authority in 2003, the midrange estimates in this paper show spending increasing more quickly than it does in CBO's baseline. *Table C-1* compares the two

projections in nominal dollars. By the last year of CBO's baseline, or 2013, the baseline estimate is less than \$40 billion, while the midrange estimate is nearly \$47 billion—a difference of about 18 percent.

The two projections differ because CBO's baseline assumes lower inflation rates over the period. In the case of the midrange estimates, medical care furnished through the

Table C-1.

Comparison of This Study's Midrange Estimates and Those in CBO's Baseline

(Budget authority in millions of current dollars, by fiscal year)

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Midrange Estimates in This Study											
Medical Spending	19,867	20,534	21,819	23,117	24,431	25,675	27,016	28,415	29,821	31,249	32,729
Accrual Charges	7,567	8,166	8,498	9,174	9,750	10,359	11,007	11,729	12,491	13,297	14,147
Estimates in CBO's March Baseline											
Medical Spending	20,217	20,722	21,231	21,795	22,377	22,992	23,627	24,291	24,979	25,681	26,390
Accrual Charges	7,279	7,734	8,217	8,731	9,277	9,856	10,472	11,127	11,822	12,561	13,346
Differences Between Midrange and Baseline Estimates											
Medical Spending	-350	-188	588	1,322	2,054	2,683	3,389	4,124	4,842	5,568	6,339
Accrual Charges ^a	288	432	281	443	473	503	535	602	669	736	801

Source: Congressional Budget Office.

- a. The difference in the estimates of the accrual charges over time are attributable solely to the different initial values in 2003; both the midrange estimates and CBO's baseline assume the same rate of growth over the 2003-2013 period. The initial values for the accrual charges in 2003 differ because the midrange estimates are based on data available in February 2003, whereas the March baseline is derived from information available in December 2002.

operation and maintenance (O&M) accounts and salaries for military doctors and nurses paid from the military personnel accounts are estimated to grow at an average annual rate of about 5.1 percent in nominal terms. The midrange estimates provided in this study represent a projection of what spending would be if it increased at the same rates as those expected for national health expenditures. Those growth rates more closely reflect what spending would need to be in order to keep benefits the same in the face of rising health care costs.

In contrast, CBO's baseline projection for DoD's medical care is constructed using methods specified under the Balanced Budget and Emergency Deficit Control Act, which requires the use of specific (and in this case, lower) inflators. In particular, CBO projects spending for medical care furnished through the O&M accounts and pay for military doctors and nurses by increasing the current year

appropriations for those items by a rate of inflation that reflects both the gross domestic product deflator and the employment cost index. That overall rate of inflation, averaging about 2.5 percent per year in nominal terms, is much lower than the estimated average increase in health care expenditures over the 2004-2013 period.

Unlike the estimates for medical spending in general, both the midrange estimates and CBO's baseline project the accrual payments for defense health care to increase at an annual nominal rate of 6.25 percent. The accrual charges are paid out of the military personnel accounts, which are adjusted to reflect the higher inflation rate. Table C-1 summarizes the comparison of the accrual and nonaccrual portions of DoD's medical spending.